DR. GREGGORY S. WILDE. DDS. MSD.

DATE _____

PATIENT INFORMATION (CONFIDENTIAL) *MINORS*

FIRST NAME	MIDDLE	LAST	PREFERRED NAME
MAILING ADDRESS			BIRTHDATE / SSN
CITY	STATE	ZIP	☐ MALE ☐ FEMALE
PHYSICAL ADDRESS *(IF DIFFERENT)*			*IF PATIENT IS A MINOR* PATIENT RESIDES WITH: ☐ MOM ☐ BOTH ☐ DAD ☐ OTHER
CITY	STATE	ZIP	
HOME PHONE ( )	CELL PHONE ☐ RECEIVES TEXTS ( )	EMAIL	
EMERGENCY CONTACT *(other than resident guardian)*	PHONE ( )	RELATIONSHIP	

1ST RESPONSIBLE PARTY & DENTAL INSURANCE *(IF APPLICABLE)* ☐ MOTHER ☐ FATHER ☐ OTHER _____

FIRST NAME	MIDDLE	LAST	BIRTHDATE	SSN
MAILING ADDRESS *(IF DIFFERENT FROM PATIENT)*			CITY	STATE & ZIP
PHYSICAL ADDRESS *(IF DIFFERENT FROM PATIENT)*			CITY	STATE & ZIP
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ☐ RECEIVES TEXTS ( )	EMPLOYER	
EMAIL			OCCUPATION	
DENTAL INSURANCE COMPANY NAME			INSURANCE PHONE NO. ( )	

PLEASE PROVIDE THE FRONT DESK WITH YOUR INSURANCE CARD ***IF THE CARD IS NOT PRESENT – PLEASE PROVIDE THE INFORMATION BELOW***

INSURANCE ADDRESS			CITY	STATE & ZIP
SSN / ID NO.	GROUP NO.	POLICY NO.	INSURANCE PHONE NO. ( )	

2ND RESPONSIBLE PARTY & DENTAL INSURANCE *(IF APPLICABLE)* ☐ MOTHER ☐ FATHER ☐ OTHER _____

FIRST NAME	MIDDLE	LAST	BIRTHDATE	SSN
MAILING ADDRESS *(IF DIFFERENT FROM PATIENT)*			CITY	STATE & ZIP
PHYSICAL ADDRESS *(IF DIFFERENT FROM PATIENT)*			CITY	STATE & ZIP
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ☐ RECEIVES TEXTS ( )	EMPLOYER	
EMAIL			OCCUPATION	
DENTAL INSURANCE COMPANY NAME			INSURANCE PHONE NO. ( )	

PLEASE PROVIDE THE FRONT DESK WITH YOUR INSURANCE CARD ***IF THE CARD IS NOT PRESENT – PLEASE PROVIDE THE INFORMATION BELOW***

INSURANCE ADDRESS			CITY	STATE & ZIP
SSN / ID NO.	GROUP NO.	POLICY NO.	INSURANCE PHONE NO. ( )	

ASSIGNMENT OF BENEFITS / FEES & PAYMENTS

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO GREGGORY WILDE, DDS FOR PROFESSIONAL SERVICES RENDERED. I AUTHORIZE THE RELEASE OF ANY DENTAL OR MEDICAL INFORMATION. ALL CHARGES ARE THE PATIENT'S RESPONSIBILITY. INSURANCE PLANS DIFFER FROM PATIENT-TO-PATIENT DEPENDING ON THE ELECTED COVERAGE AND INDIVIDUAL POLICY. THE DENTAL PROCEDURE(S) WE HAVE OUTLINED FOR YOUR CARE MAY NOT BE A COVERED BENEFIT UNDER YOUR INDIVIDUAL POLICY. THE INSURANCE COVERAGE WE HAVE ESTIMATED MAY NOT BE ACCUATE AND THE REMAINING BALANCE, IF ANY, REMAINS THE PATIENT'S RESPONSIBILITY.

X_____ DATE _____

SIGNATURE OF PATIENT OF PARENT/GUARDIAN (IF MINOR)

LOWELL STREET
Dental Implant & Surgical Center

DR. GREGGORY S. WILDE. DDS. MSD.

HEALTH INFORMATION

YES NO

☐ ☐ Are you now under the care of a physician?
If yes, please explain: _____

Name of physician: _____ Phone: (_____) _____

☐ ☐ *Have you ever been told to pre-medicate with antibiotics due to a medical condition other than infect prior to dental treatment? If yes, what antibiotic did you use?* _____

☐ ☐ Have you or are you taking medication for thinning bone or osteoporosis?

☐ ☐ Have you or are you being treated for cancer with IV bisphosphonates?
If yes, when did you start taking medication? _____

Medication: _____ Dosage: _____

☐ ☐ Have you ever used the following and if yes, please check those that apply.
□ Actonel □ Aredia □ Bonefos □ Boniva □ Didronel
□ Fosamax □ Ostac □ Skelid □ Zometa

☐ ☐ Have you ever experienced any trauma or injuries to your face or oral cavity? If yes, please explain.
_____

☐ ☐ Have you ever had any complication following dental treatment? If yes, please explain.
_____

☐ ☐ Female patients: Are you currently pregnant? If yes, what month are you due? _____

REGULAR DENTIST: _____ PHYSICIAN: _____

---------- **HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.** ----------

☐ AIDS
☐ Allergies _____ _____
☐ Penicillin Allergy
☐ Sulfa Allergy
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Blood Thinner
☐ Codeine Allergy
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Facial Pain / Pressure
☐ Dental Anxiety
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis Type _____
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nasal Obstruction
Right / Left / Both
☐ Nervous Disorders
☐ Pacemaker
☐ Post Nasal Drip
☐ Radiation Treatment
☐ Cancer Type _____
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Sleep Apnea
Device ☐ Yes ☐ No
☐ Smoker
per day _____
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers

---------- **PLEASE LIST ANY MEDICATION YOU ARE TAKING:** ----------

CONSENT FOR SERVICES

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS.

RE-SCHEDULED OR CANCELLED SURGICAL APPOINTMENTS, WITH LESS THAN 1 WEEK NOTICE, MAY BE SUBJECT TO A CANCELLATION FEE NOT TO EXCEED $500.

X_____ DATE _____

SIGNATURE OF PATIENT OF PARENT/GUARDIAN (IF MINOR)

LOWELL STREET
Dental Implant & Surgical Center

Statement of Privacy Practices
Lowell Street Implant and Surgical Center

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies but will always inform you of any changes that might affect our obligations to your rights.

Protecting your Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written permission for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Healthcare Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), email addresses, Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed, necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Healthcare Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, of disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

Your Patient Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services. An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

Statement of Financial Responsibility

Please Note: Payment is due at the time service is provided. Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and Care Credit. Alternative payment arrangements must be arranged prior to arranging treatment.

Please Note, regarding insurance:

1. We will process all of your dental insurance claims and provide you an insurance estimate. It is not a guarantee that your insurance will pay exactly as estimated. If your insurance claim is denied, you will be responsible for paying the full amount at that time. Please contact your insurance company for a detail of you benefits. Your insurance company and your plan benefits ultimately determine the amount paid.
2. All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

Missed Appointment(s) and Cancellations: In order to provide the best services to our patients, we require at least 2 business days' notice for cancellations or re-scheduling your hygiene appointments. For surgery appointments, please allow 2 weeks for cancellations or re-scheduling. We understand that unforeseen circumstances may arise, which may result in cancelling or missing your appointment. A charge may be assessed for missed, short notice, or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Communications with you: By signing below, you are authorizing us to call you at any number you provided including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing called to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account(s). You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposed or to evaluate the quality of our service, listen to a record phone conversations you have with us.

Failure to Pay:

I acknowledge failure to pay my financial obligations to Dr. Greggory S. Wilde may result in the referral of account(s) to a professional collection agency. I consent to Dynamic Collectors ***or*** its affiliates, agents or designees to obtain a copy of my credit report or any other publicly available data related to my ability to pay. In the event of any dispute regarding payment, I agree to pay all collections costs or fees including but not limited to interest at the highest rate allowable under the law attorneys' fees in the event legal action is taken.

Release of Information: I also grant permission for the office of Dr. Greggory S. Wilde to provide my information (name, contact information, date of treatment with amount incurred, amounts and dated of payments, and current balance) to Dynamic Collectors ***or*** its affiliates, agents or designees for the purpose of obtaining payments for treatment.

Phone Authorizations: I hereby grant permission and consent to Dr. Greggory S. Wilde, our assignees, and third party collection agents: (1) to contact me by telephone at any telephone number associated with me, including wireless numbers; (2) to leave answering machine and voicemail messages for me, and include in any such messages information required by law (including debt collection laws) and/or regarding amounts owed by me; (3) to send me text messages; (4) to use pre-recorded/artificial voice messages and/or an automatic dialing device (an "autodialer") in connection with any communications made to me or related to my accounts.

I understand that this agreement extends to any affiliated service providers for such services provided that may bill separately from Dr. Greggory S. Wilde including, but not limited to: radiology, laboratory, anesthesiology, pathology, or any other and accept my responsibility to pay these in accordance with the payment terms set forth by those providers. I understand that I have the right to ask about costs before services are provided to me and that costs are deemed liquidated once the provider has prepared and sent the first invoice to me.

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Lowell Street Implant and Surgical Center. The Statement of Privacy Practices describes the types of uses and disclosers of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Lowell Street Implant and Surgical Center reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) identified below. *(I understand that the default answer is "No". Without indicating "YES" in the answer to each individual question, personal protected information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)*	
☐ **YES** ☐ **NO**	Parent(s)
☐ **YES** ☐ **NO**	ANY MEMBER OF MY IMMEDIATE FAMILY: (Parent(s), Brother, Sister)
☐ **YES** ☐ **NO**	ANY MEMBER OF MY EXTENDED FAMILY: (Grandparent(s), Aunt(s), Uncle(s), etc.)
☐ **YES** ☐ **NO**	OTHER ***(PLEASE SPECIFY)***:

X_____
PRINT NAME of Patient

X_____
PRINT NAME of Guardian or Personal Representative

X_____ DATE _____
SIGNATURE of Guardian or Personal Representative

Acknowledgement of Receipt of Statement of Financial Responsibility

I acknowledge that I have received a copy of the Statement of Financial Responsibility. I have read, understand, and agree to the terms and conditions of the Statement of Financial Responsibility. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I also understand that failure to pay my financial obligations may result in the referral of my account to a collection agency.

X_____
PRINT NAME of Patient

X_____
PRINT NAME of Guardian or Personal Representative

X_____ DATE _____
SIGNATURE of Guardian or Personal Representative