

# Scott Henricksen, DDS

701 N 182<sup>nd</sup> St. Suite 102, Shoreline, WA 98133  
P 206-542-7600 | F 206-542-7727 | info@shoreline-dentist.com

Welcome and thank you for choosing us as your dental providers! Our intent is to earn the trust you have shown by choosing us as your dental office. Please help us by completing the following confidential form.

## Patient Information

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Male  Female By what name would you like us to call you? \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Marital Status  S  M  D  W

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City/State/ZIP \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

## Responsible Party (If different from above)

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City/State/ZIP \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_ Work Phone \_\_\_\_\_

## Emergency Contact

Name \_\_\_\_\_ Relationship to the Patient \_\_\_\_\_

Phone Numbers H \_\_\_\_\_ C \_\_\_\_\_ W \_\_\_\_\_

## How did you find out about our office?

\_\_\_\_\_

## Request for Confidential Communication

As my dental care provider, I give permission for you to do the following:

	YES	NO
Contact me at home	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via cell phone	<input type="checkbox"/>	<input type="checkbox"/>
Contact me at work	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via e-mail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my home answering machine	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my cell phone voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my work voicemail/answering machine	<input type="checkbox"/>	<input type="checkbox"/>

## Insurance

Subscriber's Name \_\_\_\_\_ Relationship to the Patient \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# / ID \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_

Employer \_\_\_\_\_ Group Number \_\_\_\_\_

**Do you have a secondary insurance?**  Yes  No If yes, Please complete the following:

Subscriber's Name \_\_\_\_\_ Relationship to the Patient \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# / ID \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_

Employer \_\_\_\_\_ Group Number \_\_\_\_\_

## Dental History (if information is known)

Name of previous dentist \_\_\_\_\_ Phone number \_\_\_\_\_

When was your last exam and cleaning? \_\_\_\_\_ X-Rays? \_\_\_\_\_

Do you have any questions about dentistry and oral health that you never had adequately answered for you?

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Our practice is built on providing care to satisfied patients. As said before, our intent is to earn the trust you have shown by choosing us as your dental providers. We hope to serve you in a manner that will bring you to enthusiastically recommend us to your family, friends, and others in your community. Thank you!

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## ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of the Statement of Privacy Practices for the office of Scott Henricksen, DDS, containing a more complete description of the uses and disclosures of my protected health information (PHI) under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have the right to review and receive a copy of such Statement of Privacy Practices. I understand that my dental provider has the right to change the Statement of Privacy Practices and that I may contact this office to obtain a current copy of the Statement of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

## ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information (PHI) to the person(s) identified below.

- Spouse  YES  NO
- Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses)  YES  NO
- Any Member of my extended family: (i.e. Parents, Grandchildren)  YES  NO
- Other (indicate here): \_\_\_\_\_  YES  NO

**Patient Name (please print):** \_\_\_\_\_

**Patient Signature (if 18+ years of age):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient's Personal Representative (please print):** \_\_\_\_\_

**Personal Representative Signature:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

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### FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgement of our Statement of Privacy Practices due to the following reason:

- The patient refused to sign       Communication barriers       Emergency situation       Other \_\_\_\_\_

## DENTAL RECORDS RELEASE AUTHORIZATION FORM

I, \_\_\_\_\_, authorize \_\_\_\_\_  
(Patient name) (Previous dentist/dental office)

to release copies of all information contained in my dental files. This may include, but will not be limited to, medical and dental history, radiographs, description of treatment rendered, diagnosis and prognosis, further treatment deemed necessary, and other notes and charting.

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient name:** \_\_\_\_\_

**Patient D.O.B.:** \_\_\_\_\_

**Please send to:**

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