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 Dr. A.J. Gollofon, DDS. The Statement of Privacy Practices describes the types of uses and disclosures 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.

Dr. A.J. Gollofon, DDS 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 of 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 AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ YES	☐ NO
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ YES	☐ NO
Any Member of my extended family: (Parents, Grandchildren)	☐ YES	☐ NO
Other: _____	☐ YES	☐ NO
Name of patient (please print): _____		
Patient signature: _____ DATE :		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ **Date:** _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ YES	☐ NO	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement of Privacy Practices**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

Dr. A.J. Gollofon, DDS
11285 Lake City Way NE * Seattle * Washington * 98125 * 206-363-7200

Statement of Privacy Practices

Dr. A.J. Gollofon, DDS

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 and practices but will always inform you of any changes that might affect our obligations and your rights.

Protecting your Personal 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 authorization 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), 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, or 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 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.

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Dr. AJ Gollofon, D.D.S.

Medical & Dental History

Patient Name_____DOB_____

Please list any changes, within the last year, in your general health?

_____

Approximate date of last medical exam?_____

Physician's name, address, & phone number

_____

Please check any of the following and explain

__Have you ever had complications following dental treatment?

__Are you currently under the care of a physician?

__Hospitalization within the last 5 years?

__Currently taking any prescriptions or non-prescription medicines?

If any of the above questions are marked, please explain:_____

_____

When was your last dental visit?_____

Prior dentist's name, address, & phone number_____

_____

Please check any that apply:

__Do your gums bleed when you brush or floss?
__Do your teeth experience sensitivity to cold or hot temperatures?
__Are any of your teeth currently causing you pain?
__Do you grind your teeth?
__Do you currently have any dental implants, dentures, or partials?
__Do you have any clicking, popping, or pain associated with your jaw?
__Do you have sleeping difficulties/Apnea
__Are you in any dental pain now? Explain_____

Please indicate if you have experienced any of the following:

__Heart disease
__Heart murmurs
__Stroke, hardening of arteries
__Pacemaker
__Heart attack, heart defects
__Artificial Heart Valve
__High blood pressure
__Bruising/bleeding easily

__Asthma, TB, emphysema, other lung disease
__Stomach problems, ulcers
__Arthritis, rheumatism
__Diabetes
__Jaundice
__Sinus problems
__Dry mouth
__Hepatitis, other liver disease
__AIDS
__Anemia
__Thyroid, adrenal disease
__Acid reflux/Gurd
__Fainting spells

__Tumors, cancer
__Radiation treatments
__Surgeries
__Joint pain
__Chemotherapy
__Hospitalization
__Artificial Joints

__Recreational drugs
__Alcohol or drug treatment
__Tobacco in any form
__Pregnant or nursing
__Bisphosphonates (Fosamax, Boniva, Actonel, Didrionel, Zometa, Skelid, Aredia, Reclast, Prolia, Xgeva)
__Drugs, medications, over-the-counter medicines (including aspirin), natural remedies
__Are you taking vitamins or herbal supplements?
Please list medications:_____
_____
_____
_____
__Allergies to: foods, drugs, medications, etc.
Please explain_____

Do you have any other diseases or medical problems not listed on this form?_____
_____

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Signature_____ Date_____

Dr. AJ Gollofon, D.D.S.

Patient Authorizations

Please review then initial each statement:

_____ ***I authorize*** consent for services. Financial responsibility on the part of each patient must be determined before treatment. All dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made. Patients with dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services.

_____ ***I am aware*** that I will need to provide a minimum of **2 business days notice** to change, cancel or reschedule an appointment. Otherwise a $100 missed appointment fee will be charged to my account.

By my signature below, I understand and acknowledge all of the above.

Patient Name_____ Date _____

Printed

_____ Relationship to patient_____

Signature

Dr. AJ Gollofon, D.D.S.

PATIENT REGISTRATION

(Please Print)

Name_____ DOB_____

Address_____

Phone: Home_____ Cell_____Work_____

Email _____ Social Security #_____

Male___Female___ Single___Married___Child___Other___

Spouse_____Phone_____

Whom may we thank for referring you to the practice?_____

Emergency contact: Name_____ Phone_____

Relationship_____

Employer Name_____ Phone_____

Employer Address_____

Primary Dental Insurance:

Plan name_____ Group #_____

ID#_____ Phone_____

Address_____

Insured_____ DOB_____

Secondary Dental Insurance

Plan name_____ Group #_____

ID#_____ Phone_____

Address_____

Insured_____ DOB_____

I understand to the best of my knowledge, all the above information is true and correct.

_____ _____

Signature Date