Welcome

We are pleased to welcome you to Cowlitz River Dental. Please fill out this form as completely as possible. If you have questions, we'll be glad to help you.

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS _____
STREET APT.# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME# WORK# FAX# E-MAIL

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PRIMARY INSURED / **IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY**

LAST FIRST M

STREET CITY STATE ZIP

HOME # WORK# FAX# E-MAIL#

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME # WORK# FAX# E-MAIL#

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family Household

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Has any member of your family ever been treated in our office?

☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐ Yes ☐ No

☐ Payment in full at each appointment (cash or personal check)

☐ Payment in full at each appointment (☐ VISA ☐ MC ☐ OTHER)

Card # _____ Exp. Date _____

☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

PATIENT INFORMATION

COWLITZ RIVER DENTAL

L. BLAINE KENNINGTON
358 Front Ave NW
Castle Rock WA 98611
(360) 274-9100
CRDINCR@GMAIL.COM
Fax 360-274-8152

Authorization to Release Healthcare Information

Patient's Name _____

Previous Name(s) _____

I request and authorize _____

To release healthcare information of the patient names above to:

Name: _____

Address: _____

City, St, Zip: _____

This request and authorization applies to:

_____Copies of current X-Rays and current perio charting

_____ Additional Healthcare information

_____

Signature of Patient or Patient's Authorized Representative (Guardian or Parent of minor) Date signed

_____

Relationship of Authorized Representative to Patient (if Applicable)

COWLITZ RIVER DENTAL
L. BLAINE KENNINGTON
358 Front Ave NW
Castle Rock WA 98611
(360) 274-9100

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, _____, understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my Protected Health Information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PERMISSION TO DISCUSS DENTAL TREATMENT

_____ **Publication Of Records**: I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public without my permission.

In the event that you may want a family member or friend to discuss your dental treatment with our office, we must have in writing permission/consent from you to do so. Please list any person you give Cowlitz River Dental permission/consent to discuss your dental treatment and/or financial arrangements for your treatment. Please initial the appropriate space below to give or withhold consent and sign and date the bottom portion of this form.

NAME: _____ CONTACT INFO: _____

NAME: _____ CONTACT INFO: _____

___I hereby give permission/consent to Cowlitz River Dental to discuss any and all dental treatment with the above named individuals.

___I do not wish Cowlitz River Dental to discuss any of my dental treatment with anyone other than me.

Signature: _____ DATE: _____