KARL EBERHARDT, DDS
FAMILY & COSMETIC DENTISTRY

3114 NE 65TH STREET
SEATTLE, WA 98115
(206) 524-1883

PATIENT REGISTRATION

Today's Date _____ Account Number _____

Patient's name (Mr./Mrs.) _____ Birthdate _____ Age _____
Address _____ Social Security # _____
City _____ Home Phone _____ Cell _____
State _____ Zip _____ Email _____
Occupation _____ Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered
Name of Spouse _____ SS# _____
Occupation _____ Employer _____ Business Phone/Ext. _____
Business Address _____ City _____ State _____ Zip _____
Responsible Party if Patient is a minor _____ Relationship to Minor _____
Address (Home/Business) _____ Phone (Home/Business) _____
Name, Address and Phone of relative NOT living with you: _____
Party Responsible for Payment of Account: _____

INSURANCE 1ST COVERAGE:	INSURANCE 2ND COVERAGE:
Employee Name _____	_____
Employer _____	_____
Name of Insurance Co. _____	_____
Program or Policy # _____	_____
Union Local or Group _____	_____
Employee SS# _____	_____
Birthdate _____	_____
PATIENT'S RELATIONSHIP TO SUBSCRIBER:	PATIENT'S RELATIONSHIP TO SUBSCRIBER:
☐ SELF ☐ SPOUSE ☐ CHILD ☐ DEPENDENT	☐SELF ☐SPOUSE ☐CHILD ☐DEPENDENT

ASSIGNMENT & RELEASE: I hereby authorize my insurance benefits to be paid directly to the dentist. I'm financially responsible for any balance due. I also authorize the dentist to release any information required for this claim.

SIGNED: _____ Driver's License: _____

IN CONSIDERATION OF THE SERVICES RENDERED TO ME BY THIS DENTAL OFFICE, I AM OBLIGATED TO PAY SAID OFFICE IN ACCORDANCE WITH ITS CREDIT TERMS AND POLICY.

PLEASE DATE AND SIGN:

Today's Date _____ Patient's Signature _____
(if patient is a minor, guardian or parent must sign)

DENTAL HISTORY

Referred by _____
Previous Dentist _____ City _____ How Long _____
Date of last dental check up and/or teeth cleaning _____
Why are you seeking dental care? _____
How often do you... Brush? _____ Floss? _____ See Dentist? _____
What would the loss of your natural teeth mean to you? _____

DO YOU HAVE OR HAVE YOU EVER HAD: (circle)

1. Head or Neck injuries	Yes	No	8. Orthodontic treatment	Yes	No
2. Sore or sensitive teeth	Yes	No	9. Periodontal Disease (pyorrhea)	Yes	No
3. Bleeding Gums	Yes	No	10. Trouble Opening/Closing jaw joint	Yes	No
4. Tendency to grind or clench teeth	Yes	No	11. Reaction with "Novocaine"	Yes	No
5. Difficulty chewing	Yes	No	12. Bleeding/slow healing after a tooth extraction	Yes	No
6. Anxiety with dental treatment	Yes	No	13. Dissatisfaction with appearance of teeth	Yes	No
7. Sores on lips or mouth that are slow to heal	Yes	No	14. When was your last dental x-ray taken _____		

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MEDICAL HISTORY

Your Physician _____ Type _____ How Long _____
Office Address _____ Zip _____ Phone _____

DO YOU HAVE OR HAVE YOU EVER HAD: (circle)

1. A Hospitalization for illness or surgery	Yes	No	26. Shortness of breath on mild exertion	Yes	No
2. An allergic reaction	Yes	No	27. Chest pain on mild exertion	Yes	No
3. Any reaction to:			28. Hives, skin rash, hay fever	Yes	No
a. Aspirin	Yes	No	29. Asthma	Yes	No
b. Penicillin	Yes	No	30. Emotional problems or tension	Yes	No
c. Erythromycin	Yes	No	31. Psychiatric treatment	Yes	No
d. Tetracycline	Yes	No	32. A tumor or abnormal growth	Yes	No
e. Codeine	Yes	No	33. Radiation treatment by cobalt radium, x-ray, etc.	Yes	No
f. Sedatives or sleeping pills (barbiturates)	Yes	No	34. Glaucoma	Yes	No
g. Anti-inflammatory (Ibuprofen, Advil, Motrin)	Yes	No	35. Contact lenses	Yes	No
h. Dental anesthetic	Yes	No	36. Prostate Disorders (if male)	Yes	No
i. Any other medication	Yes	No	37. Prosthetic joint (joint replacement)	Yes	No
j. Latex	Yes	No	38. Hepatitis (A B C D) Type?	Yes	No
4. Jaundice (Yellow Skin and Eyes)	Yes	No	39. AIDS (Acquired Immune Deficiency Syndrome)	Yes	No
5. Epilepsy / Seizure disorder	Yes	No	40. Herpes	Yes	No
6. Arthritis	Yes	No	41. Blood transfusion	Yes	No
7. STD (Sexually Transmitted Disease)	Yes	No	42.Taken aminobisphospanates (Fosamax, etc.)	Yes	No
8. Rheumatic Fever	Yes	No			
9. Scarlet Fever	Yes	No	ARE YOU: (circle one)		
10. Anemia or other blood disorder	Yes	No	43. Presently being treated for any illness	Yes	No
11. Prolonged bleeding due to a slight cut	Yes	No	44. Taking any medications now or within the past year	Yes	No
12. Kidney disease	Yes	No	45. Aware of a change in your general health in the past year	Yes	No
13. Diabetes	Yes	No	46. Aware of any recent weight changes	Yes	No
14. Stomach or duodenal ulcer	Yes	No	47. Subject to frequent headaches	Yes	No
15. Liver disease	Yes	No	48. A smoker (1 or more cigarettes per day)	Yes	No
16. Tuberculosis	Yes	No	a. Cigars / smokeless tobacco	Yes	No
17. Emphysema	Yes	No	b. Previous smoker	Yes	No
18. Thyroid or parathyroid disorders	Yes	No	c. Vaping / Cannabis	Yes	No
19. Heart trouble	Yes	No			
20. Heart murmur	Yes	No	IF FEMALE, ARE YOU NOW:		
21. Arteriosclerosis	Yes	No	49. Pregnant	Yes	No
22. High blood pressure	Yes	No	50. Taking birth control pills or other hormones	Yes	No
23. Low blood pressure	Yes	No	51. Premenopausal / menopausal	Yes	No
24. Excessively swollen ankles	Yes	No	52. Past menopause	Yes	No
25. A stroke	Yes	No			

PLEASE EXPLAIN FULLY ANY YES ANSWERS ABOVE: _____

PLEASE DATE AND SIGN:

Patient's Signature _____ Date _____

I HAVE NOTIFIED THE DENTIST OF ANY CHANGES IN MY MEDICAL HISTORY.

Patient's initials _____ Date _____ Patient's initials _____ Date _____

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CONTACT INFORMATION

Date: _____

Name: _____

Home Address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

PLEASE ***STAR BEST # TO CALL/CONFIRM BUSINESS DAY PRIOR TO APPOINTMENT:

Home #: _____

Work #: _____

Cell #: _____

BEST WAY TO CONFIRM APPOINTMENT WEEK PRIOR TO APPOINTMENT:

Wireless Carrier: Cell #: _____

Verizon☐ ATT☐ T-Mobile☐ Sprint☐ Qwest☐ Other☐

Email Address: _____

How do you prefer to be contacted Email☐ Text☐ Neither☐

Do you have children that are patients? Yes☐ No☐

How do you want them to be contacted?

(children over 18 years old must fill out their own contact information)

CHILDREN:

Name: _____ Contact with/phone #: _____

Name: _____ Contact with/phone #: _____

Name: _____ Contact with/phone #: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ , hereby authorize:

Name of Practice or Doctor: _____
Address: _____
_____
Phone and Fax number: _____
Email Address: _____

To release information contained in my dental records to:

Dr. Karl Eberhardt, DDS

3114 NE 65th Street

Seattle, WA 98115

Phone: (206) 524-1883
Email: karleberhardt1@qwestoffice.net

Please email any x-rays from the last 5 years and any other information that would be useful for future treatment.

Sincerely,

_____
Full Name

_____ _____
Signature Date

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FINANCIAL POLICY

PLEASE READ AND INITIAL;
***We will attempt to confirm all of your appointments at least 24 hours ahead because know you are busy. There will be a $75.00 charge for a missed appointment without 24 hours notice (emergencies excepted).

_____
Initial here

***We will be happy to assist you in billing your insurance if you like; however, your estimated co-payment will be due at the time of service. Please be advised that your insurance may not cover the entire cost of dental services performed in our office, and that you are responsible for the entire bill for dental services rendered here. We accept cash, checks and major credit cards.

_____
Initial here

***We must emphasize that, as dental care providers, we are dedicated to providing the best treatment to our patients. We will do our best in the filing of insurance claims; however, all charges are your responsibility from the date services are rendered.

_____
Initial here

Federal Truth and Lending Disclosure
There is no interest charge related to the dental fee. There is a finance charge of 1.5% per month assessed to all accounts 90 days or more past due. There will be a $25.00 fee assessed for returned checks.

_____
Initial here

***Thank you for your understanding of our office financial policy. If you have any questions, please do not hesitate to ask.

I have read and understand the above information.

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

- Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- Payment: We may use or disclose your health information to obtain payment for services we provide to you.
- Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training, programs, accreditation, certification, licensing or credentialing activities.
- Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use Your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
- To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present; then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
- Required by Law: We may use or disclose your health information when we are required to do so by law.
- Appointment Reminders: We may use or disclose your health information to provide vou with appointment reminders (such as phone voicemail messages, postcards, or letters).

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

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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. Eberhardt and Dr. Tran. 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. Eberhardt and Dr. Tran reserve 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 each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only ☐YES ☐NO
OR
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.) ☐YES ☐NO
Any Member of my extended family: (i.e. Parents, Grandchildren) ☐YES ☐NO
Other: (Please print name) _____ ☐YES ☐NO
Name of patient: (Please print) _____
Patient signature: _____
Patient's personal representative: (Please Print) _____
Personal Rep's signature: _____
Representative's Phone 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
☐Wanted to consult another person before signing
☐Physically unable to sign
☐No reason offered
☐Other: _____