# PATIENT REGISTRATION

## Patient Information

First Name: ____________________ Last Name: __________________ Middle Initial: __________

Birth Date: _______________ Soc Security: ________________ Preferred Name_________________

Address: ____________________________ Address 2: _____________________________________

City: _________________ State: ______ Zip: __________Drivers Lic: ___________________________

Home Phone: ______________ Work Phone: _______________Cellular Phone: __________________

Sex: ○Male ○ Female Marital Status: ○ Married ○ Single ○Divorced ○Widowed

Email: _______________________________ ◻ I would like to receive correspondences via email

Employment Status: ○ Full Time ○Part-Time ○Retired

Student Status: ○ Full Time ○ Part- Time **REFERRED BY**: __________________

Pref. Dentist: ___________________ Previous Dentist: __________________

Pref. Pharmacy: _________________ Emergency Contact: __________________

Pref. Hygienist: _________________ Emergency Contact #: ___________________

## Responsible Party

First Name: ____________________ Last Name: __________________ Middle Initial: __________

Birth Date: _______________ Soc Security: ________________ Preferred Name_________________

Address: ____________________________ Address 2: _____________________________________

City: _________________ State: ______ Zip: __________Drivers Lic: ___________________________

Home Phone: ______________ Work Phone: _______________Cellular Phone: __________________

## Primary Insurance Information

Name of Insured: __________________ Relationship to Insured: ○ Self ○Spouse ○Child ○Other

Insured Soc Sec.: __________________ Insured Birth Date: ________________

Employer: _______________________ Ins Company: ___________________________

Address: _______________________ Address: ___________________________

Address 2: _______________________ Address 2: _________________________

City, State, Zip: _______________________ City, State, Zip: ______________________

## Secondary Insurance Information

Name of Insured: __________________ Relationship to Insured: ○ Self ○Spouse ○Child ○Other

Insured Soc Sec.: __________________ Insured Birth Date: ________________

Employer: _______________________ Ins Company: _____________________

Address: _______________________ Address: ______________________________

Address 2: _______________________ Address 2: ____________________________

City, State, Zip: _______________________ City, State, Zip: ________________________

Navjot S. Khurana, D.M.D.

# MEDICAL HISTORY

FOR

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______

Are you on a special diet? ◯ Yes ◯ No ______

Do you use tobacco? ◯ Yes ◯ No ______

Do you use controlled substances? ◯ Yes ◯ No

**Women: Are you**

Pregnant/Trying to get pregnant? ◯ Yes ◯ No  Taking oral contraceptives? ◯ Yes ◯ No  Nursing? ◯ Yes ◯ No

**Are you allergic to any of the following?**

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: ______

**Do you have, or have you had, any of the following?**

| Condition | | Condition | | Condition | | Condition | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ◯ Yes ◯ No | Cortisone Medicine | ◯ Yes ◯ No | Hemophilia | ◯ Yes ◯ No | Renal Dialysis | ◯ Yes ◯ No |
| Alzheimer's Disease | ◯ Yes ◯ No | Diabetes | ◯ Yes ◯ No | Hepatitis A | ◯ Yes ◯ No | Rheumatic Fever | ◯ Yes ◯ No |
| Anaphylaxis | ◯ Yes ◯ No | Drug Addiction | ◯ Yes ◯ No | Hepatitis B or C | ◯ Yes ◯ No | Rheumatism | ◯ Yes ◯ No |
| Anemia | ◯ Yes ◯ No | Easily Winded | ◯ Yes ◯ No | Herpes | ◯ Yes ◯ No | Scarlet Fever | ◯ Yes ◯ No |
| Angina | ◯ Yes ◯ No | Emphysema | ◯ Yes ◯ No | High Blood Pressure | ◯ Yes ◯ No | Shingles | ◯ Yes ◯ No |
| Arthritis/Gout | ◯ Yes ◯ No | Epilepsy or Seizures | ◯ Yes ◯ No | Hives or Rash | ◯ Yes ◯ No | Sickle Cell Disease | ◯ Yes ◯ No |
| Artificial Heart Valve | ◯ Yes ◯ No | Excessive Bleeding | ◯ Yes ◯ No | Hypoglycemia | ◯ Yes ◯ No | Sinus Trouble | ◯ Yes ◯ No |
| Artificial Joint | ◯ Yes ◯ No | Excessive Thirst | ◯ Yes ◯ No | Irregular Heartbeat | ◯ Yes ◯ No | Spina Bifida | ◯ Yes ◯ No |
| Asthma | ◯ Yes ◯ No | Fainting Spells/Dizziness | ◯ Yes ◯ No | Kidney Problems | ◯ Yes ◯ No | Stomach/Intestinal Disease | ◯ Yes ◯ No |
| Blood Disease | ◯ Yes ◯ No | Frequent Cough | ◯ Yes ◯ No | Leukemia | ◯ Yes ◯ No | Stroke | ◯ Yes ◯ No |
| Blood Transfusion | ◯ Yes ◯ No | Frequent Diarrhea | ◯ Yes ◯ No | Liver Disease | ◯ Yes ◯ No | Swelling of Limbs | ◯ Yes ◯ No |
| Breathing Problem | ◯ Yes ◯ No | Frequent Headaches | ◯ Yes ◯ No | Low Blood Pressure | ◯ Yes ◯ No | Thyroid Disease | ◯ Yes ◯ No |
| Bruise Easily | ◯ Yes ◯ No | Genital Herpes | ◯ Yes ◯ No | Lung Disease | ◯ Yes ◯ No | Tonsillitis | ◯ Yes ◯ No |
| Cancer | ◯ Yes ◯ No | Glaucoma | ◯ Yes ◯ No | Mitral Valve Prolapse | ◯ Yes ◯ No | Tuberculosis | ◯ Yes ◯ No |
| Chemotherapy | ◯ Yes ◯ No | Hay Fever | ◯ Yes ◯ No | Pain in Jaw Joints | ◯ Yes ◯ No | Tumors or Growths | ◯ Yes ◯ No |
| Chest Pains | ◯ Yes ◯ No | Heart Attack/Failure | ◯ Yes ◯ No | Parathyroid Disease | ◯ Yes ◯ No | Ulcers | ◯ Yes ◯ No |
| Cold Sores/Fever Blisters | ◯ Yes ◯ No | Heart Murmur | ◯ Yes ◯ No | Psychiatric Care | ◯ Yes ◯ No | Venereal Disease | ◯ Yes ◯ No |
| Congenital Heart Disorder | ◯ Yes ◯ No | Heart Pace Maker | ◯ Yes ◯ No | Radiation Treatments | ◯ Yes ◯ No | Yellow Jaundice | ◯ Yes ◯ No |
| Convulsions | ◯ Yes ◯ No | Heart Trouble/Disease | ◯ Yes ◯ No | Recent Weight Loss | ◯ Yes ◯ No | | |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______

Comments: ______

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______ DATE ______

*We welcome difficult cases.*

# Pioneer Dental Center

## PIONEER DENTAL CENTER OFFICE POLICY

We here at Pioneer Dental Center welcome you to our clinic. Your health and well-being are our primary concerns. We hope the following information answers your questions about our services and policies.

### GENERAL INFORMATION

Our office is open to serve you during the following hours:

*Hours are subject to change seasonally*

9:00 – 5:00 Monday through Friday
9:00 – 5:00 Saturday
10:00 – 4:00 Sunday (our office is only open 1 Sunday per month)

Our office is open on the weekends and some major holidays as well. If you have an appointment scheduled during these days and you fail to notify us within 24 hours that you need to cancel or reschedule, there will be a $100.00 fee assessed to your account. In the case of a medical emergency call 911.

### APPOINTMENTS

Patients are seen by appointment and we also accepts walk-ins. Our contact information is:
110 W. Yakima Valley Highway
Sunnyside, Wa 98944
(509) 837-2200

We make every effort to be on time for our patients and ask that you extend the same courtesy to us. If you cannot keep your appointment with us, please call at least 24 hours in advance so that we may be able to use the time reserved for you for another patient.

### REGISTRATION

On your first visit to Pioneer Dental Center, you will be asked basic information to establish your medical file and account. Please bring your current insurance information at that time and notify our office of any changes in name, address, phone number or insurance as soon as possible.

### PAYMENT POLICY

Charges are payable at the time treatment or service is given. Regardless of your dental insurance coverage, our office relies on you to settle your account. For your convenience, we offer the following payment options:

1. Payment in full or payment of the portion your insurance will not cover (deductible and/or copay) on the day the service is provided.
2. Use of your VISA, MASTERCARD, DISCOVER or AMERICAN EXPRESS, checks or cash. (There is a $30.00 overdraft charge for NSF checks and credit cards)

If any other arrangements are needed, please talk to our office staff **prior to** receiving service. An interest charge of 1.5% per month (18% per year) will be charged on accounts after 60 days.

### INSURANCE

As a courtesy to you, our office will submit your initial primary insurance claim for you providing you have given us current insurance information prior to the rendered services. Subsequent submissions in case your insurance company does not pay for our services are your responsibility.

Policy coverage varies from one insurance plan to another, as do the "usual, customary and reasonable" fees that various insurances have established. Our fees are accepted by most plans, but occasionally one of our patients is notified that our services exceed "UCR FEES". **Our contractual arrangement is with you, our patient, not your insurance company.** Should there be a dispute related to the service provided or the charge for that service, the settlement of that dispute with your insurance carrier is between you and your insurance carrier. Our office is not involved in the settlement of such disputes. You are responsible for the services provided to you. With certain preferred provider organizations (PPO), special contracts may apply.

Printed Name ______________________ Signature ______________________ Date ______________

*We welcome difficult cases.*

# Pioneer Dental Center

We would like to thank you for choosing us as your Dental provider. Our staff will make every effort to ensure that your experience in our office is a positive one. Because of this, we would like to be as efficient as possible in giving you the best care available. Please know that every effort is made by our staff to verify appointments by phone with you the business day before your scheduled appointment. Therefore, it is necessary for you to notify the office within 24 hours of the intent to cancel or reschedule an appointment date. A charge of $35.00 for Monday through Thursday appointments will be assessed to patients who do not cancel or reschedule within the critical notification time frame. A charge of $100.00 for Friday through Sunday appointments will be assessed to patients who do not cancel or reschedule within the critical notification time frame.

Should you have any questions or concerns, please do not hesitate to ask any of the front office staff. They would be more than happy to assist you. Thank you for your cooperation and understanding in this matter. We look forward to providing you with the best care possible.

__________________________ __________________________

Patient Signature Date Signed

__________________________ __________________________

Witness Signature Date Signed

110 W. Yakima Valley Hwy. • Sunnyside, WA 98944 • (509) 837-2200 • Fax (509) 837-2202

# Statement of Privacy Practices
# Pioneer Dental Center

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

## Protecting your personal health care information

We use and disclose 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 dental care operations. Your personal health information will never be otherwise given to anyone, even family members, without your written consent. 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 of 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 health information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone numbers, social security number, employment date, 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 health information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

## Patient rights

You have the 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 any amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

# Pioneer Dental Center

## Acknowledgement of Receipt of State of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Pioneer Dental Center. 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 responsibility and duties to this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Pioneer Dental Center reserves the right to change the privacy practices that are 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 to me.

| ADDITIONAL DISCLOSURE AUTHORITY | | |
|---|---|---|
| In addition to the allowable disclosures in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. | | |
| ANY MEMBER OF MY IMMEDIATE FAMILY | YES | NO |
| SPOUSE ONLY | YES | NO |
| OTHER (PLEASE SPECIFY) ______________________ | YES | NO |

______________________ Name of Patient or Responsible Party

______________________ Signature of Patient or Responsible Party

______________________ Date

______________________ Description of Responsible Party's Authority

**OFFICE USE ONLY BELOW THIS LINE**

**RECORD OF ACKNOWLEDGEMENT NOT OBTAINED**

Provided prior to treatment Yes No

Date Provided______________

Reason for Denial:

- ❑ Needed more time to review statement of Privacy Practices.
- ❑ Wanted to consult with another person before signing.
- ❑ Unable to sign.
- ❑ Reason not given.
- ❑ Other (explain):______________________

*Pioneer Specialist Services P.L.L.C*

# Pioneer Endodontics/Oral Surgery

## Appointment Cancellation Policy

We realize that life doesn't always go according to plan. However for a Specialist appointment, we require that our patients provide at least one day **(24 hours)** notice should you need to cancel or reschedule an appointment for any reason.

Due to the fact that specialist appointment times are very difficult to reassign on short notice, **there will be a minimum charge of $200.00 for a missed or cancelled appointment with less than 24 hours of notice.** If a charge should occur, we will not be able to reappoint you until the balance has been cleared.

**By signing, I am stating that I have read the appointment cancellation policy, and I agree to the terms explained.**

______________________________________________

Patient's (or Responsible Party) Signature: Date:

______________________________________________

Print Name:

## Financial Information

Taking care of you and your family is our highest priority. That is why, when it comes to talking about finances, our goal is to provide you with clear information regarding our dental fees and your payment options. At the onset of treatment, we will provide you with an estimate of the fees expected. Treatment needs can change for a variety of unforeseen reasons. Whenever possible, we will inform you of any treatment changes that will affect your financial estimate.

When estimating insurance coverage, we must also stress the word estimate as dental benefits are determined by each patient's dental contract. Most dental insurance plans are designed to assist patients with their dental expenses. Very few dental plans fully cover all dental services.

As a courtesy to you, we will file your insurance forms, but we do not accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. Insurance coverage, reimbursement, and benefits are a contract between you and your insurance carrier.

**Please read and initial each statement and date below. If you have any questions regarding any of this information, please ask us-we are here to help you.**

________ I will receive an appointment confirmation at least 1 day prior to my appointment. I understand that there is a cancellation fee of $35 appointments cancelled or broken without 24 hours notice.

________An 18% annual finance charge will be applied to any balance on accounts that are 90 days past due. Monthly finance charges are 1.5%, with a monthly minimum of .50.

________My estimated portion & co-payments for treatment rendered are due at the time of service unless prior arrangements have been made.

________I understand that the Treatment Plan provided to me is for my **future** treatment needs and is only an **estimate** regarding my insurance benefits. I am responsible for all charges, including finance charges.

________I acknowledge & understand that I am ultimately responsible for knowing and understanding my dental insurance benefits.

________I understand that I am responsible for the prompt payment of my account regardless of any pending insurance claims or settlement.

________I acknowledge & understand that Pioneer Dental is a Preferred Provider for Delta Dental of Washington, Regence, Metlife, Cigna, Assurant, Principal, Guardian, Aetna, Premera and Geha ONLY. It is my responsibility to know if my insurance company requires me to see one of their Preferred Providers.

________I acknowledge & understand that even if I have dual coverage, there may be instances where the two insurances will not pay 100%. In such cases, I am responsible for any amount not paid by insurance(s).

**Person Financially Responsible**

Name________________________________ Phone_________________________

Address______________________________ Drivers License #_________________

City____________ State_____ Zip________ Social#_________________________

I have read all the information on this form and the information I have provided is true and correct to the best of my knowledge. I will notify Broadmoor Dental of any changes to my personal information, insurance plan and/or health status.

**Signature of Patient, Parent, or Guardian**________________________________ Printed Name____________________
Date_________