JONAS G. DALE, DDS, MS

JOSHUA P. DALE, DDS, MSD

PERSONAL INFORMATION

Last Name_____**First Name**_____**Middle Initial**_____

Preferred Name_____**Birth Date**_____**SSN#**_____

Mailing Address_____**City**_____**ST**_____**Zip**_____

Home Phone #_____**Cell Phone #**_____**Work Phone #**_____

Email Address _____

Employer_____**Spouse Name**_____

Person to contact in case of emergency:_____Phone #_____

Referring Dentist _____

INSURANCE INFORMATION – PRIMARY DENTAL INSURANCE

Insurance Company Name:_____

Insurance Company Address:_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____Relationship:_____

Insured's Birthdate:_____Insured's SSN:_____

Insured's Employer:_____

SECONDARY DENTAL INSURANCE

Insurance Company Name:_____

Insurance Company Address:_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____Relationship:_____

Insured's Birthdate:_____Insured's SSN:_____

Insured's Employer:_____

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years?..... YES NO

Physician's Name:_____Phone #_____

Are you now taking any medication, drugs or pills including nonprescription drugs?.....YES NO

If yes, please list:_____

For what reason?_____

Are you aware of being allergic to or ever reacted adversely to any medication or substance? ……..YES NO

If yes, please list:_____

Have you ever received or are currently receiving medication known as Bisphosphonates? .....YES NO

Indicate which of the following you have had or have at present. **CIRCLE "YES" OR "NO" TO EACH ITEM**

Allergies or Hives……YES NO	Glaucoma……YES NO	MS……..YES NO
Alzheimer's/Dementia…..YES NO	Hay Fever……YES NO	Nervous Disorder……YES NO
Anemia……YES NO	Head Injuries……YES NO	Osteoporosis……YES NO
Arthritis……...YES NO	Heart Attack……YES NO	Pacemaker……YES NO
Artificial Joints……YES NO	Heart Disease……YES NO	Pre-Medicate……YES NO
Artificial Valves……...YES NO	Heart Murmur……YES NO	Psychiatric Condition……YES NO
Blood Disease……..YES NO	Heart Surgery……YES NO	Radiation/Chemotherapy...YES NO
Cancer……YES NO	Hepatitis……YES NO	Rheumatic Fever……YES NO
COPD……YES NO	Herpes or Cold Sores ……YES NO	Sinus Problems……YES NO
Diabetes……YES NO	High/Low Blood Pressure..YES NO	Stroke……YES NO
Dizziness……YES NO	HIV Positive or AIDS……YES NO	Thyroid Problems……YES NO
Drug/Alcohol Abuse……..YES NO	Kidney Disease……YES NO	Tuberculosis……YES NO
Epilepsy……YES NO	Lung Problems ……YES NO	Ulcers……YES NO
Excessive Bleeding……..YES NO	Migraines or Headaches….YES NO	Use Tobacco ……YES NO
Fainting……YES NO	Mitral Valve Prolapse……..YES NO	Venereal Disease……..YES NO

WOMEN: Are you presently pregnant?.....YES NO Are you presently nursing?.....YES NO

Anything else we should know about your medical history?.....YES NO

If yes, explain:_____

Have you ever had any unfavorable reaction from a local anesthetic?.....YES NO

If yes, explain:_____

How long has it been since you have seen a dentist?_____

CONSENT

The undersigned hereby authorizes Dr. Jonas Dale or Dr. Joshua Dale to take x-rays, photographs, or any other diagnostic aids deemed appropriate by him to make a thorough diagnosis of the patient's medical needs, and to be used for instructional purposes as necessary.

I also authorize Dr. Jonas Dale or Dr. Joshua Dale to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Jonas Dale or Dr. Joshua Dale employ such assistance as deemed fit to provide recommended treatment.

PAYMENT IS DUE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, **we cannot *guarantee* estimated coverage**. If for some reason your insurance company has not paid their portion within sixty days from the start of treatment, you are responsible for payment at that time.

_____

Patient Signature Date

_____

Parent or Responsible Party Relationship to Patient

Jonas G. Dale, DDS, MS
Joshua P. Dale, DDS, MSD

Notice of Privacy Practices

Effective 11/01/2014

This Notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

We are required to keep your health information secure and confidential, by law. Also by law, we need to give you this Notice and to follow the terms of this Notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by another doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, for quality assessment and improvement activities, conducting training programs, and licensing activities.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call, text, or email and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner. Your health information will not be sold in any other manner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this Notice.

If we change any of the details of this Notice, we will post the new Notice clearly and prominently at our practice location, on our website, and we will provide copies of the new Notice upon request

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact Mandy at 509-928-6464 for more information, to make a request, to file a complaint with us, or for assistance regarding your health information privacy.

Jonas G. Dale, DDS, MS
Joshua P. Dale, DDS, MSD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

_____

(Please print Name)

_____

(Signature)

_____

(Date)

For Office Use Only:

We attempted to obtain a written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify):

_____

_____