# Dr. Noreen Goldwire, DDS

Family and Cosmetic Dentistry

Canyon Park Office Center
22232 17th Ave SE, Suite 208
Bothell, WA 98021
www.goldwiredental.com

Date _____

Name of Patient _____
First Middle Last Nickname

☐ Male ☐ Female ☐ Other
☐ Married ☐ Single ☐ Child Birth Date _____ Social Security # _____

Home Address _____
Street City State Zip

Email Address _____

Home Phone_____ Work Phone_____ Cell Phone_____

***Please complete this section if you would like us to submit to your dental insurance:***

Subscriber's Name _____ Subscriber's Birth Date _____

Relationship (Circle): Self Spouse Child Other _____

Insurance Company _____ Insurance ID# _____

Group/Policy # _____ Insurance Company Phone #_____

Secondary Insurance Plan: No Yes Insurance Name _____

Emergency Contact: _____
Name Phone Relationship

Who may we thank for referring you to our office? _____

***- Office Policy -***

It is our goal to provide thorough, quality care for our patients. To reduce the cost of billing the following policies have been adopted.

____ 1. No insurance: Payment for all services provided is expected at time of service.

____ 2. Insurance coverage: Your estimated portion is expected at the time of service. Dental insurance is a personal contract between you and your insurance company. Our office will verify your coverage limitations and eligibility. This is not a guarantee of benefits. Should your insurance deny/reject your claim, or you exceed your maximum benefits, you are ultimately responsible for all charges accrued on your behalf.

____ 3. Broken/missed appointments: We require 48 business hours' notice to change or cancel an appointment. Appointments changed with less than 48 hours' notice or missed appointments will be subject to a $75.00 per hour charge.

I have read, understand, and agree to the Office Policy of Dr. Noreen Goldwire's office. I authorize payment of insurance benefits to this office.

***Signature of Responsible Party _____ Date _____***

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**Medical and Dental History (Page 1)**

Date: _____

Name of Patient: _____ Birth Date: _____

Former Dentist:_____

Name City/State Phone Number

Date of Last Dental Exam: _____ Were any x-rays taken within the last year? Yes☐ No☐

## Dental History

1. Do you have any dental problems or concerns at this time? Yes☐ No☐
   If yes: Where? _____ For How Long? _____
   Describe Symptoms _____
2. Are your teeth sensitive? Yes☐ No☐
3. Do you experience sensitivity with cleanings? Yes☐ No☐
4. Can you chew comfortably? Yes☐ No☐
5. Are you happy with the appearance of your teeth? Yes☐ No☐
6. Have you ever had problems with local anesthesia (Novocain)? Yes☐ No☐
7. Have you ever had problems with dental treatment in the past? Yes☐ No☐
8. Is there anything special we can do to make your dental experience more comfortable? Yes☐ No☐

## Headache History

Do you get headaches? Yes☐ No☐

If yes, where is the pain located? _____

How often do you get headaches? _____

Please indicate your typical level of pain (low) 1 2 3 4 5 6 7 8 9 10 (high)

Have the headaches been diagnosed? Sinus☐ Muscular☐ Vascular☐ Migraine☐ Stress☐

If not diagnosed, what do you think is the cause? _____

Have you used any medication/treatments? _____

## TMJ

1. Pain in the joint itself? Yes☐ No☐ / Right☐ Left☐ Both☐
2. Clicking / Popping? Yes☐ No☐ / Right☐ Left☐ Both☐
3. Grating sound? Yes☐ No☐ / Right☐ Left☐ Both☐
4. How long have the symptoms been present? _____
5. Are your symptoms intermittent or constant? _____
6. Have your symptoms gotten better or worse? _____
7. Does anything make them worse? _____
8. Have you ever had a limitation of opening or closing your mouth? Yes☐ No☐
9. Have you had TMJ symptoms evaluated in the past? Yes☐ No☐

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**Medical and Dental History (Page 2)**

**Patient Name:** _____ **Birth date:** _____

Do you wish to use nitrous oxide for your treatment? (Typically, not covered by insurance) Yes☐ No☐

Physician _____ Location/Phone _____

*Are you currently experiencing any flu or cold like symptoms, not related to allergies?* _____

| **Have you ever had any of the following diseases or medical problems? CIRCLE Y(Yes) N(No)** | | | |
|---|---|---|---|
| A – V Shunt / CSF Shunt | Y N | High / Low Blood Pressure | Y N |
| Allergies | Y N | HIV / AIDS | Y N |
| Alzheimer's / Dementia | Y N | Implants, any type | Y N |
| Anemia | Y N | Kidney Disease | Y N |
| Arrhythmia / Pacemaker | Y N | Organ Transplant / Asplenia (no spleen) | Y N |
| Artificial Joints | Y N | Osteoporosis | Y N |
| Asthma | Y N | Prolonged Bleeding / Blood Thinners | Y N |
| Autoimmune Disorders / Lupus | Y N | Prosthetic Heart Valves / Stents | Y N |
| Cancer / Chemotherapy / Radiation | Y N | Psychiatric Problems / Depression | Y N |
| Canker Sores | Y N | Recent Surgery | Y N |
| Central IV Catheter (Hickman) | Y N | Rheumatic Fever / Scarlet Fever | Y N |
| Cold Sores | Y N | Severe or Frequent Headaches / Migraines | Y N |
| Diabetes | Y N | Sinus Problems | Y N |
| Drug / Alcohol Abuse | Y N | Stomach Ulcers / Irritable Bowel | Y N |
| Emphysema / Respiratory Problems | Y N | Stroke / TIA | Y N |
| Epilepsy / Seizure / Fainting Spells | Y N | Thyroid Disorder | Y N |
| Heart Attack / Angina | Y N | Tobacco Use (if Yes, what type _____) | Y N |
| Heart Murmur / Mitral Valve | Y N | Tuberculosis | Y N |
| Hepatitis: A, B, C | Y N | Other _____ | Y N |

♀ ***For Women**: Are you: Pregnant? Yes☐ No☐ Nursing? Yes☐ No☐ Taking oral contraceptives? Yes☐ No☐*

List any medications, vitamins, herbs, and/or over-the-counter medications:

_____ _____ _____ _____

_____ _____ _____ _____

| **Are you allergic to any of the following? CIRCLE Y (Yes) or N (No)** | | | | | |
|---|---|---|---|---|---|
| Y N | Asprin | Y N | Erythromycin | Y N | Sulfa |
| Y N | Codeine | Y N | Latex | Y N | Sedatives |
| Y N | Dental Anesthetics | Y N | Penicillin | Y N | Tetracycline |
| Please list any other drug or supplement allergies: _____ | | | | | |

***To the best of my knowledge the information I have given today is correct:***

Sign_____Date_____

Sign_____Date_____

Sign_____Date_____

Sign_____Date_____

| For Office Use Only: | |
|---|---|
| Date | Initial |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

***Dr. Noreen Goldwire, DDS***
Family and Cosmetic Dentistry

**Acknowledgement of Receipt of Statement of Privacy Practices**

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Noreen Goldwire, 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.

Noreen Goldwire, 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** |

**Patient Signature: _____ Date: _____**

**Patient Name (PRINT): _____**

| ***If you are a parent of a minor, guardian, or personal representative fill out the following.*** |
|---|
| Patient's personal representative: (Please Print): _____ |
| Personal Representative's signature:_____ |
| Representative's Telephone Number: _____Date: _____ |

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## Statement of Privacy Practices

Our office is dedicated to protecting 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 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.

**Dr. Noreen Goldwire, DDS**
**22232 17th Avenue SE, Suite 208 – Bothell, Washington 98021 - 425-485-4010**