SNYDER
FAMILY DENTAL

DANNY SNYDER D.M.D
3010 S. Southeast Blvd. Suite E
Spokane, Washington 99223
P: 509.5340569 I F: 509.5345665
www.snydersmile.com

PATIENT INFORMATION

Patient's Name: _____
LAST FIRST MIDDLE PREFERRED

Date of Birth (MM/DD/YYYY)_____ Social Security #_____

Home Phone: _____ Cell Phone _____ Work Phone _____

Mailing Address: _____
STREET CITY/STATE ZIPCODE

Email Address: _____

Whom may we thank for reffering you to our office? _____

GUARANTOR INFORMATION
(IF NOT PATIENT LISTED ABOVE)

Name: _____
LAST FIRST MIDDLE

Date of Birth (MM/DD/YYYY)_____ Social Security #_____

Home Phone: _____ Cell Phone _____ Work Phone _____

Relationship to patient:_____

Employer/Occupation:_____Employer Phone # _____

Spouse's Name: _____
LAST FIRST MIDDLE

DENTAL INSURANCE

PRIMARY

Subscriber: _____

Subscriber SSN # _____

Subscriber's Employer: _____

Insurance Compnay: _____

Member ID# _____ Group #_____

Customer Service Phone #:_____

SECONDARY

Subscriber: _____

Subscriber SSN # _____

Subscriber's Employer: _____

Insurance Compnay: _____

Member ID# _____ Group #_____

Customer Service Phone #:_____

EMERGENCY CONTACT INFOMATION

Name: _____

Relationship to Patient _____ Phone Number:_____

ASSIGNMENT OF BENEFITS:

I hereby assign any/all dental/medical benefits to which I am entitled through my health insurance be paid directly to Snyder Family Dental. I understand that I am responsible for all costs of dental treatment.

_____ Date _____
Patient or Parent/Guardian Signature

_____
Printed Name

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PATIENT MEDICAL HISTORY

Date _____

Patient's Name: _____

Date of Birth (MM/DD/YYYY)_____ Social Security #_____

Home Phone: _____ Cell Phone _____ Work Phone _____

Gender: Male Female Date of Last Physical: _____

Primary Care Physician: _____ Phone _____

Physician's Address: _____

Pharmacy: _____ Phone _____

IF FEMALE, PLEASE ANSWER:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If yes, # of weeks:
☐	☐	Are you nursing?

PLEASE ANSWER THE FOLLOWING:

Y	N	
☐	☐	Do you smoke or use tobacco?

Height: _____ Weight: _____

Please check Y (yes) or N (no) for each condition & allergy

Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Rheumatic Fever
☐	☐	Angina Pectoris	☐	☐	Seizures
☐	☐	Artifical Heart Valve	☐	☐	Sinus Prblems
☐	☐	Artificial Joints	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Thyroid Problems
☐	☐	Cancer-Chemotherapy	☐	☐	Tuberculosis
☐	☐	Congenital Heart Defect	☐	☐	Mercury Fillings
☐	☐	Diabetes	☐	☐	Fluoride Free
☐	☐	Drug Abuse	☐	☐	Interested in Changing Smile
☐	☐	Emphysema	☐	☐	Keep Remaining Teeth
☐	☐	Epilepsy	☐	☐	Bleeding Gums
☐	☐	Fever Blisters	☐	☐	Floss Regularly
☐	☐	HIV+AIDS	☐	☐	Clenching or Grinding
☐	☐	Heart Attack	☐	☐	Frequent Headaches
☐	☐	Heart Surgery	☐	☐	Pain in Jaw Joints
☐	☐	Hemophilia	☐	☐	History of Trauama to the Face
☐	☐	Hepatitis A	☐	☐	Snoring
☐	☐	Hepatitis B	☐	☐	Snoring that Disrupts Others
☐	☐	Hep C	☐	☐	Fatigue During Day
☐	☐	High Blood Pressure	☐	☐	Sleep Apnea
☐	☐	Kidney Problems	☐	☐	Tooth Pain
☐	☐	Liver Disease	☐	☐	Face Pain
☐	☐	Pace Maker	☐	☐	Take Nutritional Supplements
☐	☐	Psychiatric Problems	☐	☐	Used Botox
☐	☐	Radiation Therapy	☐	☐	Used Dermal Fillers

Allergies:

Y	N	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

OTHER:

PLEASE COMPLETE BACKSIDE

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PATIENT MEDICAL HISTORY

Please list all medications below:

Y ☐ N ☐ Is there any disease/condition, or problem you feel the office should know about that is not covered above?
If yes, please describe below:

Notes:

FOR OFFICE USE ONLY:

MEDICAL ALLERTS:

BP

HEART RATE:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my heatlh, I will inform this office without fail.

_____ Date _____

Patient or Parent/Guardian Signature

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NOTICE OF HIPAA PRIVACY PRACTICES AND DENTIST'S POLICIES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, THE PRIVACY OF YOUR HEALTH INFORAMTION IS IMPORTANT TO US.

LAWFUL REQUIREMENT

As required by the Health Insurance Portability and Accountability Act we must maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect (04/14/2003), and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time.

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 professional providing treatment to you.

PAYMENT:

We may 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 at Snyder Family Dental include administrative, financial, legal, and quality improvement activities necessary to run our practice and support the core functions of treatment and payment.

YOUR AUTHORIZATION:

In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us a 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 a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

FAMILY/FRIENDS/PERSONAL REPRESENTATIVES (S):

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 personal representative to the extent necessary to help with your healthcare, but only if you agree that we may do so.

MARKETING HEALTH-RELATED SERVICES:

We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW:

We may disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT:

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

APPOINTMENT REMINDERS:

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails, or text messages). We utilize a business associate Solution Reach to assist our practice with electronic appointment reminders. This business associate, Solution Reach, has met HIPAA privacy requirements and signed a business associate contract.

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PATIENT RIGHTS

ACCESS:
You have the right obtain copies of your health information. A written records request must be submitted documenting dates and reason for the request. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. We reserve the right to charge you a lawful fee for incurred administrative and supply expenses. These fees include $25 per hour to locate records, pages 1-30 are $1.12 per page, pages 31+ are .84 per page, postage of $.46 per ounce (if mailed).

DISCLOSURE ACCOUNTING:
You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, but not before the effective date of April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee for responding to these additional requests.

RESTRICTION:
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by your agreement (except in an emergency).

ALTERNATIVE COMMUNICATION:
You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. Your written request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT:
You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

PATIENT RESPONSIBLITIES

KNOWLEDGE OF HEALTH INSURANCE INFORMATION:
Our administrative staff will make a substantial effort to assist you with research and communication regarding your specific dental and/or medical benefits. It is ultimately your responsibility to contact your insurance company with questions concerning eligibility, benefits, and payments. Please understand an estimate of benefits is not guarantee of payment, actual benefits will be determined at the time a claim is received.

Appointment Policy:
We will make every effort to accommodate you by reserving appointment times to fit your schedule. However, we request you respect Dr. Snyder andbhis team by keeping your appointments. Last minute cancelations or rescheduling of reserved appointments cause hardships for all of us. We require 24 hrs notice of a cancelation or reschedule, otherwise the charge for a broken appointment is $75 due at the time of the next appointment.

If you have any questions regarding information contained in this Notice, please contact:
Stacey Corigliano
office@snydersmile.com
509.534.0569

_____ Date _____
Patient or Parent/Guardian Signature

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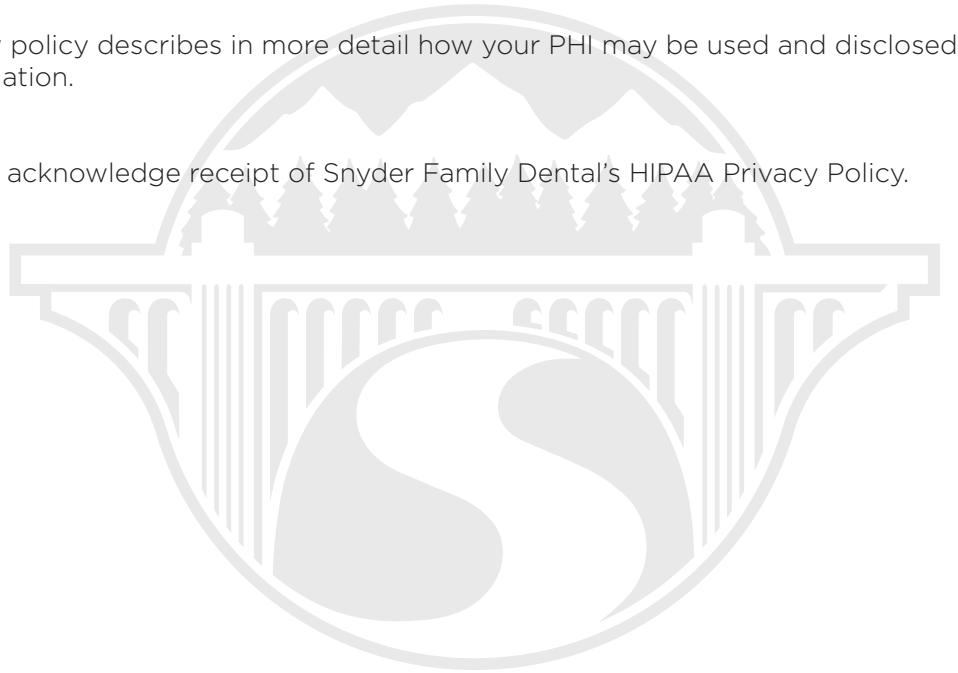
HIPPA PRIVACY POLICY ACKNOWLEDGEMENT

As required by the Health Insurance Portability and Accountability Act we must maintain the privacy of your Protected Health Information (PHI). We are also required to provide you a copy of our HIPAA Privacy Policy containing details about our legal duties and your rights concerning your PHI. We will not disclose your records to others unless you direct us to do so or required to by law.

We keep a record of the health care services we provide you. You have a right to this information, our only requirement is a written request stating which records and why you are requesting them.

Our HIPAA privacy policy describes in more detail how your PHI may be used and disclosed, and how you can access your information.

By signing below, I acknowledge receipt of Snyder Family Dental's HIPAA Privacy Policy.



_____ Date _____
Patient or Parent/Guardian Signature

_____ _____
Print Name Relationship to Patient

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FINANCIAL GUIDELINES FOR SNYDER FAMILY DENTAL

We appreciate every single patient and realize dental work can be a significant expense yet a crucial investment in one's health. We are committed to providing the best possible dental care and are here to help support our patient's oral health needs. It is important that all treatment needs and financial responsibilities are fully understood prior to beginning treatment. We strive to accurately predict the cost of dental care and work within our patient's budget.

Below is our financial policy:

If the patient has insurance:
- We will bill the insurance as a courtesy to the patient.
- The estimated patient portion is due at the time of service.

If the patient is self-pay (no insurance):
- At least half of the procedure fee is due at the time of service

We offer the following payment options:

We accept all major credit cards, including CareCredit.

We offer a 5% cash or check discount when services are paid in full at time of treatment.

With prior authorization, remaining balances may be put on the Snyder Family Dental Easy Pay Budget Plan of 3-6 month financing when placed on an auto-withdraw using a credit or debit card.
It is very important to us that you communicate any financial hardships with us so we can work with our patient on providing the dental care needed.

AGREEMENT OF FINANCIAL GUIDELINES

I request and authorize Dr. Daniel J Snyder to provide _____ with dental care. I understand that I am personally responsible for the charges of the services received.

I agree to make payment in full for services received. I understand that regardless of dental insurance benefits, any treatment is my financial responsibility.

I hereby authorize Dr. Snyder at his discretion, to bill my insurance carrier and any other persons or parties who may be liable for payment of these services. I also authorize my insurance carrier to make payment directly to Dr. Daniel J Snyder.

_____ Date _____
Patient or Parent/Guardian Signature

_____
Print Name

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CANCELLATION & NO-SHOW POLICY

We appreciate you and understand your time is valuable which is why we make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you. We reserve the right to charge patients who do not cancel with adequate notice or who fail to keep their scheduled appointments. To respect the needs of all Snyder Family Dental patients, if it is necessary to cancel your reserved appointment we require that you contact our office 48 hours in advance. Appointments are in high demand and your early cancellation will give another person the opportunity to access timely dental care.

A 'no-show' appointment occurs when a patient misses an appointment without cancelling 48 hours in advance. Missed appointment are an inconvenience to patients who need access to dental care in a timely manner; is inconsiderate to our doctor and team who are left sitting idle. Last minute/late cancellations are considered 'no- show' appointments. We reserve the right to charge for any appointment(s) broken without 48 hours' notice. The charge will be $75 per ½ hour of hygiene scheduled and $150 per ½ hour scheduled with the Doctor. These fees are not covered by insurance and are the sole responsibility of the patient. Fees must be paid in full prior to the patient's next appointment. Habitual missed/cancelled/rescheduled appointments may result in a patient being required to either pay up front prior to scheduling an appointment or this office may no longer be available to provide dental services for the patient.

Our voice mail is available for messages left after business hours, however if a message is left after business hours cancelling an appointment for the next day this will be subject to our fee. We understand that extreme/unavoidable emergencies or circumstances do arise which may require you to cancel your appointment, and individual circumstances will be taken into consideration.

Our practice firmly believes that good physician/patient relationship is based on trust and good communication. Questions about cancellation and no-show fees should be directed to Stacey.

By signing below, I acknowledge receipt of Snyder Family Dental's Cancellation and 'No-Show' Policy.

_____ Date _____
Patient or Parent/Guardian Signature

_____
Print Name