PATIENT REGISTRATION

Patient's Name _____ Birth Date _____

Name of Spouse _____ Birth Date _____

If a Child, Parent's Name _____

Single ☐
Married ☐
Divorced ☐
Separated ☐
Other ☐

Street Address _____ Home Phone _____

City _____ State _____ Zip _____

E-mail _____

Cell Phone _____

Patient employed by _____ Work Phone _____

Business Address _____

Present Position _____ How long held _____

Purpose of this appointment _____

Emergency contact _____ Phone _____

Person responsible for this account _____

Social Security number _____

Driver's License number _____

Spouse's Social Security number _____

If you have insurance, name of insured _____ Policy No. _____

Name and address of insurance company _____

If Spouse has insurance, name of insured _____ Policy No. _____

Name and address of insurance company _____

Whom may we thank for referring you _____

Your Signature _____ **Date** _____

Comments: _____

TRAVELLE
FAMILY DENTISTRY
GENERAL, AESTHETIC & IMPLANT DENTISTRY

- Patient Financial Policy -

Dr. Daniel Travelle • Dr. Katie McKay Travelle
115 South 177th Place
Burien, WA 98148
tel (206) 242-1500 • fax (206) 246-1565

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable we are pleased to offer a variety of payment options.

As courtesy, we will process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office, this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received. .75% per month interest, nine percent (9%) per year will be charged on accounts 90 days from treatment date. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

Please make your questions and concerns known to our Accounts Manager who is happy to discuss this policy and ensure that you have an outstanding experience.

I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____

Signature (responsible party) Date

STATEMENT OF PRIVACY PRACTICES

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 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 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 (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 Health 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 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.

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 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.

Please ask if you have any questions about your privacy rights or the protection of your health information.

Daniel Travelle, DDS
115 South 177 Place • Burien, WA. 98148

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. Daniel Travelle. 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. Daniel Travelle 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
Name of patient (please print): _____		
Patient signature: _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone 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:**	

Daniel Travelle, DDS
115 South 177 Place • Burien, WA 98148

Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have questions, don't hesitate to ask.

Patient Name:_____ Date of Birth_____

Physician _____ Date of Last visit_____

MEDICAL HEALTH HISTORY:

Do you have or have you ever had any of the following? Please check all that apply.

__ Alcohol / Drug dependency
__ Anemia or Other Blood Disorder
__ Angina
__ Antidepressant Medication
__ Any type of Transplant
__ Arthritis
__ Artificial Prosthesis (i.e., heart valve or joints)
__ Asthma
__ Aware of a change in your general health
__ Hospitalization for Illness or Injury
__ Blood Transfusion
__ Cancer
__ Chemotherapy
__ Colitis
__ Contact Lenses
__ Cough
__Diabetes
__ Do you smoke? How Much _____
__ Do you use smokeless Tobacco
__ Epilepsy, Convulsions (Seizures)
__Emphysema
__FEMALE – Pregnant
__FEMALE – taking Birth Control pills
__Frequent Headaches
__Glaucoma
__ Head or Neck Injuries
__Heart Murmur *
__ Heart Pacemaker
__ Heart Problems
__ Hepatitis (Type ___)
__ Herpes – cold sores / blistering
__ High Blood Pressure
__ HIV Positive, ARC, AIDS
__Jaundice
__Kidney Disease
__ Liver Disease
__ MALE- Prostate Disorders
__ Mitral Valve Prolapse *
__Often Exhausted or Fatigued
__Presently treating for any Illness
__Prolonged Bleeding
__Psychiatric Treatment
__Radiation Therapy
__Rheumatic Fever *
__Scarlet Fever
__ Sexually Transmitted Disease
__Shingles
__Sinus Problems
__Stroke
__Thyroid Disease
__Tuberculosis (TB)
__Tumor, Abnormal Growth
__Ulcers

*MAY REQUIRE PRE-MED

Have you ever taken any of these medications?

Diet Medications:	__Dexfenfluramine	__Fen-phen	__Pondimin	__Redux
Blood Thinners:	__Coumadin	__Warfarin		
Other:	__Levoxyl	__Synthroid	__Fosamax	

CHECK IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING (i.e. itching, rash, swelling of hands/feet):

__Aspirin
__Codeine
__Dental Anesthetic
__Erythromycin
__Fluoride
__Jewelry
__Latex
__Metals (gold, stainless steel)
__Penicillin
__Please list any other drugs/ materials that you are allergic to: _____
_____

Please list all medications you are currently taking:

Name/Dosage	Reason for Taking	Name/Dosage	Reason for Taking

Please mark any questions you would answer "YES"

Are you apprehensive about dental treatment? ☐

Have you had any problems with previous dental treatment? ☐

Do you gag easily? ☐

Do you wear dentures? ☐

Does food catch between your teeth? ☐

Do you have difficulty chewing your food? ☐

Do you chew only on one side of your mouth? ☐

Do you avoid brushing any part of your mouth because of pain? ☐

Do your gums bleed easily? ☐

Do your gums bleed when you floss? ☐

Do your gums feel tender or swollen? ☐

Have you ever noticed slow-healing sores in or around your mouth? ☐

Are your teeth sensitive? ☐

Do you feel twinges of pain when your teeth come into contact with:

- Hot foods or liquids? ☐
- Cold foods or liquids? ☐
- Sours? ☐
- Sweets? ☐

Do you take fluoride supplements? ☐

Are you dissatisfied with the appearance of your teeth? ☐

Do you prefer to save your teeth? ☐

Does your jaw make noise so that it bothers you or others? ☐

Do you clench or grind your jaws frequently? ☐

Do your jaws ever feel tired? ☐

Does your jaw get stuck so that you can't open freely? ☐

Does it hurt when you chew or open wide to take a bite ☐

Do you have earaches or pain in front of the ears? ☐

Do you have any jaw symptoms or headaches upon waking in the morning? ☐

Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities? ☐

Do you find jaw pain or discomfort extremely frustrating or depressing? ☐

Do you take medication or pills for pain and discomfort (pain relievers, muscle relaxants, antidepressants)? ☐

Do you have temporomandibular disorder (TMD, TMJ)? ☐

Do you have pain in the face, cheeks, jaws, joints, throat, or temples? ☐

Are you unable to open your mouth as far as you want? ☐

Are you aware of an uncomfortable bite? ☐

Have you had a blow (trauma) to the jaw? ☐

Are you a habitual gum-chewer or pipe smoker? ☐

Do you want complete dental care? ☐

Do you have any other disease, condition, or problem not listed previously that you feel we should know about? If so, please describe:

_____

_____

STATEMENT OF ACKNOWLEDGEMENT

Dental diseases are caused by a combination of factors – some are more complex than others. Definitive treatment is prescribed to control specific etiologic factors present in each particular case.

The success of treatment is dependent on many factors, including the severity of periodontal destruction, the patient's general physical status and, as you will soon learn, the patient's ability and willingness to perform proper oral hygiene on a regular basis. As with treatment of the most complex disease, no cure can be guaranteed. As with treatment of any condition, especially where drugs and surgical procedures are being used, unsuspected problems can arise. Such problems can include hemorrhage, prolonged numbness in a treated area, sensitivity to medications, and incomplete healing. Also, other problems such as loose teeth, sensitivity to hot and cold, pulp damage, and tooth loss can be encountered.

We will make every effort to keep you informed of the treatment outlined for you. Also, feel free to ask questions. Your involvement and understanding are very important to the long term success of your treatment.

PLEASE INFORM THE DOCTOR IF YOUR HEALTH CHANGES IN ANY WAY.

If there is any further information that you feel we should be aware of, please write it here: _____

_____

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his Staff, and assume financial responsibility. I have reviewed my medical and dental history, as well as the statement of acknowledgement, and have updated any changes.

Date: _____ Signature: _____ Date: _____ Signature: _____

Date: _____ Signature: _____ Date: _____ Signature: _____

Date: _____ Signature: _____ Date: _____ Signature: _____

Date: _____ Signature: _____ Date: _____ Signature: _____

Sleep Screening Questionnaire

Please answer the questions below to help us assess the possibility of a sleep disorder which may be related to your dental and overall health. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke. If you are here with your child (under 16), please fill out the lower portion marked "For children only" for your child.

Name:_____ **Height:**_____ **Weight:**_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	**Chance of Dozing**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theater or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____
Total Score	_____

Have you ever been diagnosed with:	**Yes**	**No**
1. Impaired Cognition (i.e. difficulty concentrating or thinking)	☐	☐
2. Mood Disorders/Depression	☐	☐
3. Insomnia	☐	☐
4. Hypertension (high blood pressure)	☐	☐
5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	☐	☐
6. History of Stroke	☐	☐
7. Sleep Apnea	☐	☐
If yes: Did you try to use CPAP	☐	☐
8. TMJ problems significant enough to require treatment	☐	☐
9. Gastric Reflux (GERD) or Heartburn	☐	☐

Are you aware of (or have you been told):	**Yes**	**No**
1. Snoring on a regular basis	☐	☐
2. Feeling tired or fatigued on a regular basis	☐	☐
3. Clenching or grinding your teeth (bruxism)	☐	☐
4. Having frequent headaches	☐	☐
5. Your neck size being > 17 inches (male) or > 16 inches (female)	☐	☐
6. Anyone in your family having sleep apnea	☐	☐
7. Stopping breathing when sleeping/awakening with a gasp	☐	☐

For children only (filled out by parent or guardian)

Are you aware of your child:	**Yes**	**No**
1. Snoring/noisy breathing while sleeping	☐	☐
2. Grinding his or her teeth	☐	☐
3. Wetting the bed	☐	☐
4. Having difficulty in school/learning	☐	☐
5. Being treated for ADD or ADHD	☐	☐
6. Breathing primarily through their mouth	☐	☐
7. Having frequent nightmares/night terrors	☐	☐
8. Having frequent ear aches	☐	☐

Dental Exam Findings:
☐ Evidence of Bruxism ☐ Scalloping of the tongue ☐ Crowded airway
☐ Tori or Bone Loss ☐ Anterior wear ☐ Retrognathia / Class II