*Joseph C. Mecca, DMD*
*14535 Bel-Red Rd., Ste. 102 * Bellevue, WA 98007 * 425-865-8128*

# Patient Information

*Name: _____ Hm Phone: _____ Wk Phone:_____*

*Cell Phone: _____ email address: _____*

*Home Address: _____ City:_____ Zip Code:_____*

*Social Security #: _____ Date of Birth: _____*

*Employer: _____ Phone: _____*

*Spouse's Name: _____ Wk phone: _____*

*Nearest Relative not living with you: _____Phone: _____*

*Nearest Friend not living with you: _____Phone: _____*

*Whom may we contact in the case of emergency? _____ Phone: _____*

*Whom may we thank for referring you to our office? _____*

*Who is responsible for this bill? _____*

*I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.*

_____ _____
*Signature* *Date*

_____ _____
*Parent (if minor)* *Date*

***If you have dental insurance please complete other side…***

*Joseph C. Mecca, DMD*

# Patient Dental Insurance

*Patient Name:* _____ *Date of Birth:* _____

*Subscriber Name:* _____ *Date of Birth:* _____

*Relationship to Patient:* _____

*Subscriber's Address:* _____ *City:* _____ *Zip Code:* _____

*Employer:* _____

*Insurance Co:* _____ *Phone:* _____

*Insurance Co. Address:* _____

*Subscriber's Ins. ID#:*_____ *Group #:* _____

***If patient is covered by secondary dental insurance:***

*Subscriber Name:* _____ *Date of Birth:* _____

*Relationship to Patient:* _____

*Subscriber's Address:* _____ *City:* _____ *Zip Code:* _____

*Employer:* _____

*Insurance Co:* _____ *Phone:* _____

*Insurance Co. Address:* _____

*Subscriber's Ins. ID#:*_____ *Group #:* _____

*I hereby authorize insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines the necessity.*

_____ _____ _____

*Responsible party* *Relationship* *Date*

# ***HEALTH HISTORY***

Patient's name: _____

Physician's Name: _____ Phone: _____

***Do you have any history of or difficulty with any of the following? If yes, please check.***

__ Aids
__ Antidepressant Medication
__ Arthritis, Rheumatism
__ Artificial Heart Valves
__ Asthma
__ Back Problems
__Bleeding abnormally, with Extractions or surgery
__ Blood Disease
__ Cancer
__ Chemical Dependency
__ Chemotherapy
__ Circulatory Problems
__ Congenital Heart Lesions
__ Cortisone Treatments
__ Cough, Persistent or bloody
__ Diabetes
__ Do you wear contact lenses?
__Do you participate in sports?
__ Emotional Problems
__ Emphysema
__ Epilepsy
__ Fainting or dizziness
__ Glaucoma
__ Headaches
__ Head or Neck Injuries
__ Heart Murmur
__ Heart Problems
__ Hepatitis Type ____
__ Herpes/Cold Sores
__ High Blood Pressure
__ HIV Positive
__ Jaw tenderness
__ Joint Replacement
__ Kidney Disease
__ Liver Disease
__ Low Blood Pressure
__ Mitral Valve Prolapse
__ Pacemaker
__ Psychiatric Care
__ Radiation Treatment
__ Respiratory Disease
__ Rheumatic Fever
__ Scarlet Fever
__ Shortness of Breath
__ Sinus Trouble
__ Skin Rash
__ Special Diet
__ Stroke
__ Swelling of Feet /Ankles
__ Swollen Neck Glands
__ Thyroid Problems
__ Tobacco Habits
__ Tonsillitis
__ Tuberculosis
__ Tumor or growth on head/neck
__ Ulcer
__ Weight Loss, unexplained
__ FEMALE-taking birth control pills
__ Are you Pregnant?
Due date_____
__ MALE-prostate disorders
__ Other _____

## *Allergies:*

__ Aspirin
__ Barbiturates (Sleeping Pills)
__ Codeine
__ Erythromycin
__ Fluoride
__ Iodine
__ Latex_____
__ Local Anesthetic
__ Penicillin
__ Sulfa
__ Metal
__ Other_____

***Please list any medications you are currently taking:_____***

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*I have read all the information on both sides of this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status on the above information.*

_____ _____
*Signature* *Date*

_____ _____
*Parent (if minor)* *Date*

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# ***DENTAL HISTORY***

Reason for today's visit: _____

_____

Former Dentist _____City/State _____

Date of last dental visit:_____ Date of last full mouth xrays: _____

Date of last dental cleaning_____

How often do you have your teeth cleaned? _____

How often to you floss? _____ How often do you brush?_____

***Do you have any history of or difficulty with any of the following? If yes, please check.***

__ Awaken with awareness of teeth or jaws
__ Bad Breath
__ Bleeding Gums
__ Blisters on lips or mouth
__ Burning Sensation on Tongue
__ Chew on one side of mouth
__ Cigarette, pipe or cigar smoking
__ Clench or grind your teeth
__ Clicking or popping jaw
__ Difficulty swallowing
__ Difficulty opening your mouth widely
__ Dry mouth
__ Fingernail biting
__ Food collection between teeth
__ Gums swollen or tender
__ Jaw pain or tiredness
__ Do you have, or have you ever worn a nightguard
__ Lip or cheek biting
__ Loose teeth or broken fillings
__ Mouth breathing
__ Mouth pain, brushing
__ Orthodontic treatment
__ Pain around ear
__ Preference for no dental anesthetic
__ Periodontal Treatment
__ Sensitivity to cold
__ Sensitivity to heat
__ Sensitivity to sweets
__ Sensitivity to biting
__ Sores or growths in mouth
__ Stiff neck muscles
__ Unhappy with the appearance of your teeth
__ Have you ever worn removable partial dentures

***Please complete health history on the other side….***

**Office and Financial Policy**
**Dr. Joseph Mecca**

Patient Name: _____ Date: _____

It is our goal for our patients to clearly understand their treatment needs, as well as their financial responsibility and our office policies. Dental treatment is an excellent investment in an individual's medical and psychological well-being. We are always available to answer your questions and/or assist you in any way we can.

***For Patients with Dental Insurance**: Please understand that our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such; many routine and necessary dental services are not covered, even though you may need those services.*

*If you provide us with complete and updated insurance information, we will be happy to submit your claims and help you receive the maximum benefits due you, but please understand that we cannot accept responsibility for collecting an insurance claim, or for negotiating disputed claims. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment. However, please know that we will do everything possible to see that you receive the full benefits of your policy.*

**Payment Options:**

- In addition to check and cash, we gladly accept VISA / MasterCard / Discover Card or American Express. There is a $35.00 fee on all returned checks.
- For those who wish to finance their dental treatment over 90 days, we offer ***Care Credit.***
- For patients without dental insurance, we are happy to offer a 5% accounting courtesy for all treatment when paid the day of service.
- For treatment plans over $300.00, payment arrangements of up to 90 days may be made in advance with the financial coordinator.

**Cancellation Policy:**

Because we reserve appointments especially for you, we ask that you please give us at least 48 hours notice on all appointment changes. A cancellation fee is applied to broken appointments unless there is a minimum of 24 hours working day notice given.

A finance charge of 1.5% per month (or a rebilling fee minimum of $1.50) is applied on all account balances after 90 days.

*I hereby assign to the dentist, all payment for dental services rendered. I have read and understand the above office and financial policy. Regardless of insurance coverage, I am responsible for payment of all dental fees for myself and/or my dependents. Any insurance claim not paid in full after 90 days will become my responsibility to pay at that time. I authorize Dr. Mecca to furnish information to insurance carriers (if applicable) concerning me or my dependents' dental treatment.*

*Signature:* _____ *Date:* _____

# STATEMENT OF PRIVACY PRACTICES

**Joseph C. Mecca, DMD**
**14535 Bel-Red Rd., 102**
**Bellevue, WA 98007**
**425-865-8128**

We, at Joseph C. Mecca, DMD, are 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 principle 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 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 number(s), Social Security Number, employment data, medial 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 proved information to law enforcement and government 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, postcards, and e-mails.

## PATIENT RIGHTS

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.

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

**Joseph C. Mecca, DMD**

Joseph C. Mecca, DMD
14535 Bel-Red Rd., Ste. 102
Bellevue, WA 98007
425-865-8128

## 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 Joseph C. Mecca, DMD. 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 oral 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.

Joseph C. Mecca, DMD 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 described 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 Signature of Patient or Personal Representative

_____ _____
Date Description of Personal Representative Authority

**For Office Use Only:**

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other