

*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...***



# **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.***

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

***Allergies:***

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Fluoride         | <input type="checkbox"/> Penicillin  |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Iodine           | <input type="checkbox"/> Sulfa       |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Latex _____      | <input type="checkbox"/> Metal       |
| <input type="checkbox"/> Erythromycin                  | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> 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*

## **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.***

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

***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, 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 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**

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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.

<u>ANY MEMBER OF MY IMMEDIATE FAMILY</u>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<u>SPOUSE ONLY</u>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<u>OTHER (please specify)</u>	<input type="checkbox"/> YES	<input type="checkbox"/> 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