Timothy J. Butson, DMD, MSD, PLLC

REGISTRATION FORM

Patient's name_____ Social Security#_____

Gender: Male___ Female___ Age____ Birthdate_____

Address_____City_____State_____Zip_____

Employed by_____Occupation_____

Home phone_____Business phone_____

Cell phone _____ E-mail address _____

Business address_____City_____State_____Zip_____

Spouse's name_____Birthdate_____

Employed by_____Social Security #_____

Business address_____City_____State_____Zip_____

Person financially responsible_____

Name of Primary Dental Insurance_____

Address of insurance company_____

Name of insured_____SS# of insured_____

Group/Policy#_____EffectiveDate_____

Patient's relationship to insured (circle one): Self Spouse Child Other

Name of Secondary Dental Insurance_____

Address of insurance company_____

Name of insured_____SS# of insured_____

Group/Policy#_____Effective Date_____

Patient's relationship to insured (circle one): Self Spouse Child Other

In case of emergency, call_____Phone#_____

Whom may we thank for referring you?_____

I authorize payment of the Dental benefits directly to the attending dentist.

Signature_____Date_____

DENTAL HISTORY

What is your chief dental concern at this time?_____

_____

How long since your last dental visit?_____Last cleaning?_____

Are your teeth sensitive to hot or cold? Yes / No
Any complications with extractions? Yes / No
Do your gums bleed easily? Yes / No
Do you have any fears about dental treatment? Yes / No
Have you had any difficulty with dental anesthetic? Yes / No
Have you ever been treated for gum disease? Yes / No
Are you aware of any lumps or swelling in your mouth? Yes / No
Do you grind or clench your teeth (day or night)? Yes / No
Are you satisfied with your teeth and gums? Yes / No
Would you like your teeth to be whiter? Yes / No
Do you have any breath concerns? Yes / No
How often do you brush your teeth?_____x/day floss?_____x/day

MEDICAL HISTORY

Physician's Name_____Phone #_____
Date of your last physical exam_____Are you under the care of a physician now? Yes / No
If yes, please explain_____
Name of medications taken within the last year_____

_____

Do you smoke? Y / N If yes, how many packs per day?_____For how long?_____
ARE YOU ALLERGIC TO ANY MEDICATIONS, LATEX OR METALS? Yes / No
IF YES, WHICH ONES?_____
Women: Are you currently pregnant? Yes / No
Are you taking birth control pills or female hormones? Yes / No

Please circle responses to the following:

Heart Problems	Yes / No	TMJ Problems	Yes / No
Stroke	Yes / No	Abnormal Bleeding	Yes / No
High Blood Pressure	Yes / No	Anemia	Yes / No
Heart Murmur	Yes / No	Asthma	Yes / No
Rheumatic Fever	Yes / No	Sinus Trouble	Yes / No
Joint Replacement	Yes / No	Tuberculosis	Yes / No
Heart Valve Replacement	Yes / No	Tonsillitis	Yes / No
Allergic to Anesthetics	Yes / No	Fungal or Candidiasis	Yes / No
Hepatitis / Jaundice	Yes / No	Herpes Virus / Cold Sores	Yes / No
Epilepsy	Yes / No	Venereal Disease	Yes / No
Diabetes	Yes / No	Alcohol or Chemical dependency	Yes / No
Kidney / Liver Problems	Yes / No	Nervous Problems	Yes / No
Ulcer	Yes / No	(psychiatric treatment)	
Tumor / Abnormal Growth	Yes / No	AIDS / HIV Positive	Yes / No
Malignancies / Radiation	Yes / No	OTHER_____	

Comments regarding any of the above conditions:_____

_____

SIGNATURE OF PATIENT_____DATE_____
I certify that the above information is current and correct and that I will notify this office of any changes.

SIGNATURE OF DENTIST_____DATE_____

FINANCIAL POLICY

Our office strives to maintain a high-quality, personal dental practice committed to excellence, caring and affordability. Our goal in treating you is to involve you as an active participant in your dental care. In order for us to provide quality, efficient and affordable service, we ask that you keep your account current. This will reduce billing and fee collecting costs and ultimately reduce fees charged to you.

PAYMENT: Fees are established according to services performed and payment is due at the time of service unless you have insurance, or other arrangements are made. ***Statements are mailed monthly and a 1% service charge is assessed on any unpaid balance after 90 days regardless of insurance coverage***. Should your account be referred to collections, you will be obligated to pay all reasonable collection expenses, i.e., the fees normally charged to this office by the collection agency, interest, and/or attorney and court costs.
NOTE: Our office does not carry accounts for longer than 90 Days.

INSURANCE BILLING & PAYMENTS: To prevent misunderstanding, we wish our patients to know that insurance policies vary and that it is ***your*** responsibility to pay for services provided, regardless of your individual coverage. This office will do everything we can to help our patients recover benefits, and ***as a courtesy*** we will bill your insurance company directly. We ask that you familiarize yourself with your insurance plan, and make the necessary financial arrangements with us on your estimated portion before treatment is started; we can assist you in estimating the amount your insurance will cover. ***Please note that an estimate is never a guarantee of coverage***. Please forward any checks sent to you by your insurance company. This helps us determine whether your insurance company has paid on all of your claims. Your adherence to our policy greatly improves our ability to serve you.
NOTE: In the event your insurance company requests additional information such as x-rays, detailed correspondence, or an additional doctor's review, an administrative fee will apply. This fee is determined based on the amount of additional time, and materials, needed to further expedite your claim.

APPOINTMENTS: We know that your time is valuable and we make every effort to stay on schedule, however, emergency patients are sometimes referred to the office on short notice. If we are behind schedule in these situations, we appreciate your understanding. We realize that your schedule may change and that it may be necessary for you to change an appointment. We request that you notify our office as soon as possible. ***A charge will be assessed for missed appointments, and late cancellations, with less than 2 business days notice***.

If you have any questions regarding the above policy, please do not hesitate to ask.

I understand and agree to the terms of this financial policy, and I hereby authorize my insurance benefits to be paid directly to my dentist.
I also consent to the making of photographs and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or for teaching purposes.

Signature_____Date_____

DR. TIMOTHY J. BUTSON
600 UNIVERSITY STREET, SUITE 819
SEATTLE, WA 98101
206-624-7706

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 Timothy J. Butson, DMD, MSD, PLLC. 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.

Timothy J. Butson, DMD, MSD, PLLC 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 information to the persons indicated below.

1. Any member of my immediate family ☐ YES ☐ NO
2. Spouse Only ☐ YES ☐ NO
3. Other (please specify) ☐ YES ☐ NO

_____ _____
Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

_____ _____
Date Description of Personal Representative's Authority

_____

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

Provided prior to treatment? ☐ **YES** ☐ **NO**
Date provided:

Reason for denial:
- ☐ Needed more time to review Statement of Privacy Practices.
- ☐ Wanted to consult with another person before signing.
- ☐ Unable to sign.
- ☐ Reason not given.
- ☐ Other (explain) _____

NOTICE OF PRIVACY PRACTICES

Dr. Timothy J. Butson

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all healthcare records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations…or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Jeana Murray
Timothy J. Butson, DMD, MSD, PLLC
600 University St. Ste. 819
Seattle, WA 98101
206-624-7706

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)