



Paul G. Hutchinson, D.M.D. & Associates

PATIENT INFORMATION

Last Name _____ First _____ Middle _____
What do you preferred to be called in our office? _____ Male/Female (circle one)
Date of Birth _____ Social Security# _____ Marital Status: M S W D
Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____
Email _____ Best time and place to reach you _____
Occupation _____
Employer _____ Phone _____
Whom may we thank for referring you ? _____

SPOUSE / PARENT or GUARDIAN

Name _____ Relationship to Patient _____
Date of Birth _____ Social Security # _____
Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____
Employer _____ Phone # _____
Emergency contact (if different) _____ Phone # _____

INSURANCE INFORMATION

Primary Dental Insurance _____	Secondary Insurance _____
Employee Name _____	Employee Name _____
Employee SS# / ID# _____	Employee SS# / ID# _____
Date of Birth _____	Date of Birth _____
Employer _____	Employer _____
Insurance Address _____	Insurance Address _____
_____	_____
Insurance Phone _____	Insurance Phone _____
Group Policy # _____	Group Policy # _____



Paul G. Hutchinson, D.M.D. & Associates
NEW PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____
Medical Doctor's Name: _____ Physician's Ph# _____
Preferred Pharmacy (Name and City) _____

- Checkboxes for various medical conditions: AIDS/HIV, Anemia, Arthritis, Rheumatism, Artificial Heart Valves, Artificial Joints, Asthma, Back Problems, Bleeding abnormally, Blood Disease, Cancer, Chemotherapy, Circulatory Problems, Heart Lesions, Cortisone Treatments, Cough, persistent or bloody, Diabetes, Emphysema, Epilepsy, Fainting or dizziness, Glaucoma, Headaches, Heart Murmur, Heart Problems, Hepatitis, Herpes, High Blood Pressure, Low Blood Pressure, Jaundice, Jaw Pain, Kidney Disease, Liver Disease, Mitral Valve Prolapse, Nervous Problems, Pacemaker, Psychiatric Care, Radiation Treatment, Respiratory Disease, Rheumatic Fever, Shortness of Breath, Sinus Trouble, Skin Rash, Stroke, Swelling of Feet or Ankles, Swollen Neck Glands, Thyroid Problems, Tonsillitis, Tuberculosis, Tumor or growth on head or neck, Ulcer, Venereal Disease, Weight loss or gain, unexplained, Other.

Women: Are you now or do you plan to become pregnant? Yes/No Due Date: _____
Are you nursing? Yes/No Taking birth control pills? Yes/No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis

ALLERGIES

- Checkboxes for allergies: Aspirin, Codeine, Latex, Penicillin, Barbiturates, Local Anesthetic, Iodine, Sulfa. Metals, if so, type: _____ Other _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Phone # _____

Last Dental Visit _____ Last Dental X-rays _____

- Checkboxes for dental concerns: Cigarette, pipe or cigar smoking, Food collection between teeth, Gums, swollen or tender, Mouth breathing, Chronic or recurrent sinus problems, Sensitivity to cold, Sensitivity when biting, Sensitivity to heat, Sensitivity to sweets, Clicking or popping jaw, Dry Mouth, Lip or cheek biting, Mouth pain, Periodontal treatment, Sores or growths in mouth, Jaw pain or tenderness, Teeth grinding, Loose teeth or broken fillings, Pain around ear, Orthodontic treatment, Rigorous sports: football, baseball, wrestling, etc.

Other dental concerns _____

Signature _____ Date _____



PAUL G. HUTCHINSON, D.M.D.
& ASSOCIATES

FINANCIAL POLICY

I, the undersigned, understand that I am financially responsible for all charges *whether or not* paid by insurance (if applicable), and that any balance over 90 days is subject to a finance charge of 1% per month (12% annually).

By providing my cellular, landline, or any other number(s), I expressly consent to receiving communications from the providers and staff of South Kitsap Family Dentistry and any collector agents that they are contracted with, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voicemail, text message, using an auto-dialer or other computer assisted technology, pre-recorded message(s), or by any form of electronic communication, including any email address I provide, in connection to my *dental health and financial purposes*.

(If applicable) I, the undersigned, certify that I (and/or my dependent(s)) have insurance coverage and assign directly to South Kitsap Family Dentistry all insurance benefits. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. The information that I have provided is true and accurate to the best of my knowledge.

I am consenting to treatment to be provided to me by the staff of South Kitsap Family Dentistry.

Signature of Responsible Party

Date

1953 Pottery Avenue, Port Orchard, WA 98366
(360)876-6211

South Kitsap Family Dentistry

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**. I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

Special Privacy Protections:

Some health information may be protected by additional state or federal confidentiality laws. Our practice complies with these laws, and details are included in our Notice of Privacy Practices, available upon request

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**I authorize South Kitsap Family Dentistry to discuss my treatment and account information with the following*

Name(s) _____

**I do , I do not want relevant treatment information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:*

Patient Name _____

Date of Birth _____

Signature _____

Date _____

Relationship to Patient _____

~~~~~  
**FOR ADULT PATIENTS UNDER THEIR PARENTS INSURANCE** *(Please initial one):*

\_\_\_\_ I authorize \_\_\_\_ I DO NOT authorize any information regarding my treatment and/or billing and account information to be released to either parent at any time it is requested.

For Office Use Only:

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

The patient refused to sign                       Communication barriers                       Emergency Situation

Other \_\_\_\_\_

1953 Pottery Avenue, Port Orchard, WA 98366 (360) 876-6211

1953 Pottery Avenue, Port Orchard, WA 98366 (360) 876-6211

# South Kitsap Family Dentistry

---

1953 POTTERY AVENUE  
PORT ORCHARD, WA 98366

Telephone (360) 876-6211  
Fax (360) 876-7952

## CANCELLATION AND NO-SHOW POLICY

A 24-hour notification will be required for all cancelled appointments. Cancellation of an appointment less than 24 hours prior will be considered a No Show and will result in a cancellation fee. Office policy states that you will be withdrawn from the practice for 3 missed appointments per family. A warning letter will be sent after your first missed appointment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

***\*The above signed acknowledges receipt of cancellation/no show policies***

### **Family members also covered by this acknowledgement**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\*Appointment reminders via text and email are automated.  
Please call our office for any changes to your current appointments.