



## INSURANCE INFORMATION

Name of insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Birth date: \_\_\_\_\_ SSN/ID#: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ City/State: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Ins. co. address: \_\_\_\_\_ City/State: \_\_\_\_\_

Do you have any secondary insurance?  Yes  No If yes, complete the following:

Name of insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Birth date: \_\_\_\_\_ SSN/ID#: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ City/State: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Ins. co. address: \_\_\_\_\_ City/State: \_\_\_\_\_

## FINANCES

Payment in full is expected at each appointment. We will provide each patient with a detailed financial explanation after the initial consultation and for any changes in treatment.

We do request 48 business hours notice to cancel or change an appointment in order to avoid a fee. The charged fee is \$100. We do keep a credit card on file for each patient. If you do not provide 48 business hours notice to cancel or change a surgery appointment, we will charge the card on file.

My signature below signifies that I accept financial responsibility for this account and that the information provided is accurate and true. It signifies that I authorize Dr. Scott Clayhold's office to hold a credit card on file for the specific use of a \$100 cancellation fee for surgeries cancelled with less than 48 business hours notice.

\_\_\_\_\_  
Patient Signature (or parent if patient is a minor)

\_\_\_\_\_  
Date

## Authorization, Release, & Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third-party payors and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.



# DOCTOR SCOTT CLAYHOLD

SPECIALIZING IN ORAL SURGERY AND IMPLANTS

## HEALTH HISTORY RECORD

### PERSONAL INFORMATION

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: M or F (circle)

PARENT/GUARDIAN: \_\_\_\_\_

### HEALTH HISTORY

Physician's Name \_\_\_\_\_

Are you currently taking any prescription, no prescription, or herbal medications? \_\_\_ Yes \_\_\_ No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Are you allergic to:

Any drugs or medications? \_\_\_ Yes \_\_\_ No

If yes, please list: \_\_\_\_\_

Local anesthetics (Novocain, etc.) \_\_\_ Yes \_\_\_ No

Latex or rubber products \_\_\_ Yes \_\_\_ No

Soybeans \_\_\_ Yes \_\_\_ No

Eggs or Yolk \_\_\_ Yes \_\_\_ No

Other: \_\_\_\_\_

Do you have or have ever had:

Scarlet Fever or rheumatic fever \_\_\_ Yes \_\_\_ No

Congenital heart disease \_\_\_ Yes \_\_\_ No

Cardiovascular disease (heart trouble) \_\_\_ Yes \_\_\_ No

● Angina (chest pain) \_\_\_ Yes \_\_\_ No

● Damaged heart valve \_\_\_ Yes \_\_\_ No

● Heart murmur \_\_\_ Yes \_\_\_ No

● Heart attack \_\_\_ Yes \_\_\_ No

If yes, when: \_\_\_\_\_

● Heart surgery \_\_\_ Yes \_\_\_ No

If yes, when: \_\_\_\_\_

● High blood pressure \_\_\_ Yes \_\_\_ No

● Low blood pressure \_\_\_ Yes \_\_\_ No

● Pacemaker \_\_\_ Yes \_\_\_ No

● Stroke \_\_\_ Yes \_\_\_ No

Lung disease \_\_\_ Yes \_\_\_ No

● Asthma \_\_\_ Yes \_\_\_ No

● Bronchitis \_\_\_ Yes \_\_\_ No

● Emphysema \_\_\_ Yes \_\_\_ No

● Shortness of Breath \_\_\_ Yes \_\_\_ No

● Tuberculosis \_\_\_ Yes \_\_\_ No

Cancer treatment \_\_\_ Yes \_\_\_ No

● Surgery \_\_\_ Yes \_\_\_ No

● Radiation \_\_\_ Yes \_\_\_ No

● Chemotherapy \_\_\_ Yes \_\_\_ No

● Oral drugs for cancer treatment \_\_\_ Yes \_\_\_ No



**ACKNOWLEDGEMENT  
OF  
PRIVACY PRACTICES**

Scott Clayhold, DMD  
22605 SE 56<sup>th</sup> Street #110  
Issaquah, WA 98027  
425-369-1533

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*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or 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.

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

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

\_\_\_\_\_

Additional Disclosure Authority:

- Any member of my immediate family \_\_\_\_\_  Yes  No
- Spouse only \_\_\_\_\_  Yes  No
- Other-specify \_\_\_\_\_  Yes  No

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**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