Cascade Oral Medicine Inc., P.S.

Marijoyce R. Leynes, DDS, MSD

2504 E. Bakerview Rd.; Bellingham, WA 98226 ~ Phone: 360.383.6824 ~ Fax: 888.972.9695
www.cascadeoralmed.com ~ leynes@cascadeoralmed.com

PATIENT REGISTRATION

DATE:

Patient Information			
Last Name	First Name	Middle	Birthdate
Gender identity:	Parent/Guardian (if minor)	Occupation	
Phone 1: Cell/Home/Work	Ok to lv msg? Y / N	Phone 2: Cell/Home/Work	Ok to lv msg? Y / N
Mailing Address		Employer/School Email address	
Emergency Contact & Relationship		Emergency Contact Phone	
Dentist's Name		Physician's Name	
Dentist's Address and Phone		Physician's Address and Phone	
Referred by:		Referring Doctor's Phone	

Insurance Information					
Primary **Medical** Insurance Company Name & Address Medical Insurance Company Phone:			Secondary **Medical** Insurance Company Name & Address Medical Insurance Company Phone		
Subscriber's Name			Subscriber's Name		
Subscriber's ID	Subscriber's DOB	Group/Plan #	Subscriber's ID	Subscriber's DOB	Group/Plan #
Subscriber's Employer & Phone #			Subscriber's Employer & Phone #		
Primary **Dental** Insurance Company Name & Address Dental Insurance Company Phone:			Secondary **Dental** Insurance Company Name & Address Dental Insurance Company Phone:		
Subscriber's Name			Subscriber's Name		
Subscriber's ID	Subscriber's DOB	Group/Plan #	Subscriber's ID	Subscriber's DOB	Group/Plan #
Subscriber's Employer & Phone #			Subscriber's Employer & Phone #		

I certify that the information above is correct. I hereby authorize Cascade Oral Medicine, Inc., P.S. and staff to send an electronic medical claim on my behalf. I understand that full payment is due at the time of service with the exception of Tricare insurance plans not affiliated with Medicare. I authorize Cascade Oral Medicine, Inc., P.S to release information required for this claim.

_____ _____

Patient/Guardian Signature **Date**

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STATEMENT OF PRIVACY PRACTICES

Thank you for entrusting us with your care. We are committed to protect the privacy rights of our patients and the confidential information provided to us. We will strive to ensure that your health information is not compromised.

Protecting your Personal Health Care 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 health care operation. Your personal health information will not 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 office and electronic system are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our policy and practices apply to all former, current, and future patients. Rest assured that your protected health information will not be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our high standard of quality health care, implement payment activities, conduct health care 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 governmental officials under certain circumstances.

Patient Rights

You have the right to request copies of your healthcare information 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 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 may also notify the U.S. Department of Health and Human Services.

I certify that I have read and understand the above statement. The Statement of Privacy Practices describes the types of uses and disclosures of my protected information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices is also posted in the facility. I give permission to my dentist to exchange information with other physicians, dentists, and health care professionals, only when necessary, to facilitate my care.

I understand that my appointment time has been reserved especially for me. Failure to give 24 hours notice of cancellation or reschedule will result in a $150 fee. Exceptions may be made for extenuating circumstances.

Please check if you agree (leave blank if you do not agree):

- ○ I give permission for my extraoral and intraoral clinical photos and biopsy slides to be used for only the purposes of teaching or professional education. I understand that no information such as name and birthdate will be attached to my photo that will enable my identification.
- ○ I give permission to the doctor and staff to request and share health care information, records, and imaging from my other healthcare providers and labs.
- ○ I give permission to the doctor and staff to leave a message on my phone numbers listed on my registration page.
- ○ I give permission to the doctor and staff to provide health information to _____. My relationship to this person is: _____.
- ○ I give permission for the doctor and staff to email me information and understand that their emails are encrypted and secure.

_____	_____	_____
Printed Name	**Signature**	**Date**