Smile Secrets

Gentle Family & Cosmetic Dentistry

Welcome!

Welcome to our private care dental office. My Team and I consider ourselves a group of Health Care Professionals whose primary concerns are the prevention and treatment of dental disease and the creation of pleasing aesthetics in those guests who choose to place themselves in our care.

We believe in providing Excellence. Each of us maintains a continuing commitment to progress, innovation and education, with the goal of developing the best dental care possible.

We establish our treatment based on the principle of choice. We respect your right to choose what you think is best for your future health, based on the most current and complete information we can provide. It is our sincere hope that you will strive for the highest level of quality care.

A result of this philosophy is our stellar reputation, and our passion for excellence and innovation in dentistry. Our guests have come to know what they can expect of us: only the very best!

Dr. Kari Chellis, RDH, DDS

Seattle Met 2018 TOP DENTIST

Jefferson Square Professional Building, 4700 42nd Ave SW, Suite 555, West Seattle, WA 98116
206.935.5522 p 206.932.4577 f info@SmileSecrets.com

Great Looking Smiles

Help People Feel More Confident!

We improve the quality of our patient's lives by helping them achieve optimal dental health. Optimal dental health contributes to overall physical well-being, improving self-esteem and peace of mind.

Our innovative approach to preventing and healing disease helps our patients look and feel better.

We ask questions and listen intently to the desires of our patients allowing their priorities, values and expectations to guide us. We want our patients to be informed and involved.

We provide service that is gentle and supportive as well as technically advanced.

Our dentistry withstands the test of time. We will not cut corners!

We want our work to inspire you to refer your family members and friends.

STATEMENT OF PRIVACY PRACTICES

Dr. Kari D. Chellis
4700 42nd Ave SW
Suite 555
Seattle, WA 98116
206.935.5522

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee is to ensure that your health information is never compromised. 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.

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 require by law. We are obligated to provide information to law enforcement and governmental 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 appointment including voice-mail messages, answering machines and postcards.

Patients Rights

You have a right to request copies of your healthcare information, to request copies in a variety of formats, and 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 you an amount allowed by law for your copies. 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 in our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Patient Information

Date:		Preferred Name (Nickname):	
Patient Name: Last		First	MI
Title: ☐ Mr ☐ Ms ☐ Mrs ☐ Dr	SS #: - -	Gender: ☐ Male ☐ Female	
Address:	City	State	Zip
Email Address		Birth date:	
Family Status: ☐ Married	☐ Single	☐ Child	☐ Other
Place of Employment:		Position:	

Home Phone:	Cell Phone:	Work Phone:
Best time and number to call:		
We confirm all appointments via e-mail or text message or both. What is your preferred method of correspondence?		
☐ Email ☐ Text Message ☐ Both		

Whom may we thank for referring you to our office? Name _____
How did you hear about us? Please check all that apply: ☐ Google ☐ Facebook ☐ Website ☐ Online Reviews ☐ Other
If patient is under the age of 18, parent or guardian's signature:
In case of emergency, please notify: Name: Phone: Relationship:

Smile Secrets

Gentle Family & Cosmetic Dentistry

Primary Insurance Information

Name of Insured: Last	First	Middle	
Insured's Birth Date:	ID #:	Group #	
Insured's Address:	City	State	Zip
Insured's Employer Name:			
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Insurance Plan Name:	Primary Dental Insurance Phone Number:		
Insurance Address:	City	State	Zip

Additional Insurance Coverage

Name of Insured:	Last	First	Middle
Insured's Birth Date:	ID #:	Group #	
Insured's Address:	City	State	Zip
Insured's Employer Name:			
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Insurance Plan Name:	Secondary Dental Insurance Phone Number:		
Insurance Address:	City	State	Zip

Payment is expected at or before the time of service. A deposit is expected to reserve your appointment.

Sedation Appointments and Appointments two hours or longer must be prepaid.

We accept cash, checks, debit cards, and Visa/Mastercard/Discover/American Express.

Payment plans through Care Credit and Lending Club are available. All payment plan arrangements must be made in advance of appointments.

Insurance: We will bill your insurance company as a courtesy to you. Although we will estimate your what your insurance company MAY pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance at the time of service. Your policy is a contract between you and your insurance company. Please refer to your benefits manual to know your particular plan's coverage.

Premera/Regence Blue Cross: Your insurance company pays you. Your portion is due at the time of service & full payment is expected immediately after the insurance company pays you.

Appointments: We consider all appointments confirmed at the time they are scheduled. We request a courtesy of a 2-business-day/48 hour-notice for all appointment changes.

I authorize my insurance company to pay all benefits for services rendered. If for any reason the estimated amount is not paid by my insurance, it will become my responsibility. We reserve the right to charge a 12% Finance Charge on Account Balances over 60 days old.

I acknowledge the above, I agree to the terms, and I am responsible for all treatment fees for services performed on myself and my family.

Signature:_____Date:_____

Getting to Know You

What attracted you to our office?

What would you like to have happen today?

What are your main concerns?

☐ Comfort ☐ Health ☐ Endurance ☐ Appearance

What would you like us to know about you and your past dental experiences?

- ☐ It has been good.
- ☐ I've had bad experiences.
- ☐ Please handle me with care!
- ☐ My teeth are very sensitive.
- ☐ I'm very anxious about injections.
- ☐ I want to be very numb!
- ☐ I gag easily.
- ☐ I feel out of control in the dental chair.
- ☐ I've had braces.
- ☐ I've had an accident that affected my teeth.
- ☐ I've had (or have) TMJ pain.
- ☐ It would help me if you could explain to me what you are doing and why.
- ☐ I have an extreme problem with lying down.
- ☐ I need help getting back on track!
- ☐ I don't want to be lectured about my mouth.
- ☐ I have not been to the dentist in a long time and I feel worried about what you will say about my teeth, or my oral hygiene.
- ☐ I have a specific dental problem now. Please describe:

Please tell us a little about yourself. For example, family, pets, hobbies, interests, etc.

How is your overall physical (non-dental) health?

☐ Great! ☐ Good ☐ Fair ☐ Poor ☐ Frail

What are your expectations for a successful result?

- ☐ Relief from Tooth Pain
- ☐ Relief from Headache Pain
- ☐ Dental Health
- ☐ Chew better
- ☐ Help me save my teeth!
- ☐ Reduce my "Gummy Smile"
- ☐ Other. Please describe:
- ☐ Whiter Teeth
- ☐ Straighter Teeth
- ☐ A Smile Makeover
- ☐ Reduce Facial Lines & Wrinkles
- ☐ Look more youthful
- ☐ I want complete dental care
- ☐ I'm not sure yet, but tell me about my options

What would you like to know about us?

- ☐ Will I feel any pain?
- ☐ Do you have "Laughing Gas"?
- ☐ Can I sleep through my appointments?
- ☐ Can you minimize the number of visits?
- ☐ Can you minimize the number of times I have to get numb?
- ☐ Other. Please describe:
- ☐ What are your Infection Control Procedures?
- ☐ How much time will this take?
- ☐ Do you have payment plans?
- ☐ Do you have room for my family and friends?

What special things can we do in our office to make sure you are well cared for?

Health History

Date of last medical exam?	**Date of last dental exam?**

Have you been hospitalized in the last 5 years? **If yes, what for?**	☐ Yes	☐ No
Are you currently receiving care? **If yes, what is the nature of your care?**	☐ Yes	☐ No
Are you required to Pre-Medicate? If yes, for what reason:	☐ Yes	☐ No

Please list the names and phone numbers of all physicians who are currently providing you care:

Please list all prescription medications you are currently taking and for what reason:
Please note that if you don't recall the name of your medications, Dr. Chellis will need you to email/fax or drop by our office with your list of medications, as soon as possible, before any treatment.

☐ No Prescription Meds

Please list any OTC medicines you are currently taking:

☐ No OTC Meds

Please list any herbal supplements, including vitamins, that you are currently taking:

☐ No Supplements

Are you allergic to:

- ☐ No Known Allergies to medications
- ☐ Local Anesthetics
- ☐ Valium
- ☐ Other antibiotics Please list:
- ☐ Other sedatives Please list:
- ☐ Other allergies Please describe:
- ☐ Sulfa
- ☐ Penicillin
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Codeine

Your Height:	**Your Weight:**	**BMI**:

Is your Blood Pressure: ☐ Normal
☐ Low
☐ High

Do you take any medications for Blood Pressure?
☐ No
☐ Yes

Have you ever had or do you have any of the following conditions?

☐ Snoring
☐ Stop breathing at night?
☐ Wake feeling fatigued?
☐ Feel sleepy during the day
☐ Heartburn or Acid Reflux
☐ Neck or Back pain/problems
☐ Arthritis
☐ Migraines
☐ Grind your teeth

Have you ever had or do you have any of the following conditions?

☐ Heart Attack within the last 6 months
☐ Heart Disease, Attack or Surgery
☐ Abnormal Heart Condition
☐ Bacterial Endocarditis
☐ Prosthetic Heart Valves or Stents
☐ Congestive Heart Disease, excluding MVP
☐ Heart Transplant
☐ Rheumatic Fever
☐ Abnormal Bleeding from a cut
☐ Asthma
☐ Emphysema or other Respiratory Illness
☐ Anemia
☐ Epilepsy
☐ Thyroid Condition
☐ Liver Disease (including Jaundice)
☐ Kidney Disease
☐ Joint Replacement
☐ Hepatitis, Any Form
☐ Drug/Alcohol Addiction
☐ Previous Biopsies
☐ Radiation Therapy
☐ Unintentional Weight Loss/Gain
☐ Mental Disorder
☐ Nervous Condition or Depression
☐ Herpes/Cold Sores
☐ Sore/Enlarged Lymph Nodes
☐ Slow-Healing Mouth Sores
☐ Rheumatoid Arthritis
☐ Glaucoma
☐ Eating Disorder
☐ Latex Sensitivity
☐ Sleep Apnea

☐ **Cancer** What type and when? _____

☐ **HIV+ or AIDS related Complex** What was your last CD4 Count? _____

☐ **Diabetes** What was your last HbA1c?
☐ < 6.5% ☐ 6.5 –8.5% ☐ > 8.5%

☐ **Osteoporosis or Osteopenia**
Have you ever taken bisphosphonates (Fosamax, Actonel, etc)? ☐ Yes ☐ No

Do you use tobacco products or recreational drugs of any kind?

☐ Never ☐ I quit. When? _____ ☐ Occasionally How much/day? _____ ☐ Yes. How much/day? _____

☐ Cigarettes
☐ Cigar
☐ Pipe
☐ e-Cigarettes
☐ Chew
☐ Marijuana
☐ Other

Do you drink alcohol of any kind?
☐ Never ☐ < 1 drink per day ☐ 1-2 drinks per day ☐ > 2 drinks per day

For Women:

Are you Pregnant?	☐ Yes	☐ No
Are you planning a pregnancy in the near future?	☐ Yes	☐ No
Are you a Nursing Mother?	☐ Yes	☐ No
Are you taking Birth Control Pills? If Yes, what brand? _____	☐ Yes	☐ No

Do you have now or have you ever had TMJ/jaw discomfort/headaches?	☐ Yes ☐ No
Have you ever felt or heard problems with your jaw joint? ☐ Popping ☐ Sounds ☐ Difficulty Opening ☐ Locking Open/Closed ☐ Pain	☐ Yes ☐ No
How often do you notice jaw joint problems? ☐ I have problems sometimes ☐ I have problems regularly ☐ I used to, but don't anymore ☐ I don't have any of these	
Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐ Yes ☐ No
Do you avoid or have any difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐ Yes ☐ No
Have your teeth changed in the last five years, becoming shorter, thinner or worn?	☐ Yes ☐ No
Are your teeth crowding or developing spaces?	☐ Yes ☐ No
Do you have more than one bite, or do you clench (squeeze) to make your teeth fit together?	☐ Yes ☐ No
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐ Yes ☐ No
Do you clench your teeth in the daytime or make them sore?	☐ Yes ☐ No
Do you wake with sore teeth or jaws or has anyone ever told you that you grind your teeth at night?	☐ Yes ☐ No
Do you feel you have trouble breathing through only your nose?	☐ Yes ☐ No
Do you have any problems with sleep or wake up with an awareness of your teeth?	☐ Yes ☐ No ☐ I have Sleep Apnea
Do you wear or have you ever worn a bite appliance such as a Nightguard? ☐ I've been told I should ☐ I tried to but I quit ☐ I wear one regularly ☐ I wear one rarely	☐ Yes ☐ No

For Patients interested in Sedation Dentistry:

Do you take any form of Antacids (TUMS, Cimetidine/Tagamet, Omeprazole/Prilosec, Nexium)? ☐ No ☐ Sometimes ☐ Yes, regularly ☐ Every meal	
Do you take St John's Wort? ☐ No ☐ Sometimes ☐ Regularly ☐ Daily	
Do you drink grapefruit juice or eat fresh grapefruit? ☐ No ☐ Sometimes ☐ Yes, regularly ☐ Every meal	
Do you take Protease Inhibitors (Nefazadone/ Serzone, etc)?	☐ Yes ☐ No
Do you take FLUoxetine/Prozac?	☐ Yes ☐ No
What is your approximate Blood Pressure? (Normal = 120/80) _____ / _____	
What is your approximate Weight?	
How much sugar is there in your diet?	☐ Slight ☐ Moderate ☐ High
Do you smoke? Do you use any form of marijuana?	☐ Yes ☐ No ☐ Yes ☐ No

I understand the above information is necessary to provide me with optimal dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I agree to notify you, Dr. Chellis, at every visit of any future changes in my health and/or medications.

I hereby authorize Dr. Chellis' office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right to Dr. Chellis to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Dr. Chellis warranties the materials she uses and the workmanship of her restorative care for a period of 5 years. To keep your warranty in effect, you must:

1. Be in compliance with Smile Secrets' policies regarding payment and cancelled or missed appointments (less than 2 business days-notice is considered a missed appointment) and
2. Be seen at least annually for a Hygiene visit and Examination by Dr. Chellis,
3. Be following Dr. Chellis' recommendations.

Often small problems can be corrected, if found early. Your warranty covers loss, fracture of, or defects discovered in the restoration. Replacement due to new caries (decay) is <u>not</u> a covered benefit under this warranty.

Signature:_____ Date: _____

Smile Secrets

…for dentistry that withstands the test of time…!

Appointment Cancellation Guidelines

We strive to provide excellent dental care to you and the rest of our patients. To be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time is reserved and set aside for you only, and when the appointment is missed, that time cannot be used to treat another patient.

We require a **48 Business Hours**-notice for all appointment changes. If you need to reschedule your appointment, please call one of our Team members at 206.935.5522 during Smile Secrets regular business hours (M, T, W: 7-4 & Th: 7-2) to give us 48 hours-notice (not including Friday, Saturday or Sunday). This allows for other patients to be scheduled into the appointment that you had previously reserved with us.

If you cancel or miss an appointment without contacting our office within the required time, it will be considered a missed appointment.

For Hygiene Services (teeth cleaning, etc.):

A Missed Appointment Fee of $50.00 will be charged; this fee cannot be billed to your insurance company and will be your direct responsibility to pay.

For Doctor's Services:

A Missed Appointment Fee of $100.00 per scheduled hour of Dr. Chellis' time will be charged; this fee cannot be billed to your insurance company and will be your direct responsibility to pay.

For both Hygiene and Doctor's appointments, you will also be required to pre-pay $50.00 to reschedule. The $50.00 Rescheduling Fee will be applied toward future treatment not covered by your insurance.

If you cancel again, you will forfeit the Rescheduling Fee and will be charged a second Missed Appointment Fee. In no instance will the Rescheduling Fee be refunded to you. Second missed appointments will be charged a higher fee.

We do not accept cancellations by Voicemail. You must speak to one of our Team Members during our regular business hours. Any cancellations left via Voicemail will automatically be subject to both the Missed Appointment Fee and the Rescheduling Fee.

If you have any questions regarding this policy, please let one of our Team Members know and we will be glad to clarify any questions you may have.

We thank you for your patronage and appreciate your cooperation and the courtesy of allowing our other patients to have an appointment time that you cannot make it to.

I have read and understand the Appointment Cancellation Policy of Smile Secrets and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature:_____ Date: _____

Smile Secrets by Dr. Kari Chellis
4700 42nd Ave SW, Suite # 555
Seattle, WA, 98116

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Dr. Chellis' Notice of Privacy Practices. The Notice 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's health care operations. The Notice of Privacy Practices also describes my rights and Dr. Chellis' duties with respect to my protected health information. The Notice of Privacy Practices is posted in the facility.

Dr. Chellis reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.				
SPOUSE/PARTNER: ***PLEASE SPECIFY NAME:***	☐	**YES**	☐	**NO**
IMMEDIATE FAMILY: ☐ ***MOTHER,*** ☐ ***FATHER,*** ☐ ***SIBLINGS,*** ☐ ***CHILDREN*** ***PLEASE SPECIFY NAME(S):***	☐	**YES**	☐	**NO**
OTHER: (***PLEASE SPECIFY NAME(S***):	☐	**YES**	☐	**NO**

_____ _____
Name of Patient **Signature of Patient** or Guardian

_____ _____
Date If Guardian, Relationship to Patient

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED				
PROVIDED PRIOR TO TREATENT?	☐	**YES**	☐	**NO**
DATE PROVIDED:				
REASON FOR DENIAL:	☐	NEEDED MORE TIME TO REVIEW NOTICE OF PRIVACY PRACTICES.		
	☐	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.		
	☐	UNABLE TO SIGN.		
	☐	REASON NOT GIVEN.		
	☐	OTHER (EXPLAIN):		