6					6			_				
Preventive · Rostenative · Connective · Dentivery												
	Statement of Privac	cy Practices		Preventive • Rostonative • Councile • Destivity Lee and Van Mieghern, DDS						Refer a friend and rec	eive a dinner gift card!	
Our office is dedicate	ed to protect the privacy rights	of our patients and the confiden	itial	19718 68th Avenue W, Suite G Lynnwood, Washington 98036						Write your name belo		
information entrusted	d to us. The commitment of eac	ch employee to ensure that your	health	425-778-6677						your friend to bring w	ith them on their first	
to time, amend ou				Acknowledgement of Receipt of Statement of Privacy Practices				1	Velcome!	appointment. Referred by:		
that might affect 3		STEPHEN R. L	EE, D.D.S.		Acknow	ledgement of Receipt of S	Statement of Privacy Practices		vercome!	Referred by:		
Protecting Your I	JOSEPH VAN MIEC	SHEM. D.D.S.	RALPH G. STI	ENBERG, D.D.S.	I acknowledge that I	have received a copy of the State	ement of Privacy Practices for the offices	s of Lee Ir	order for us to be prepared for your			
We use and discle	se and discle				disclosures of my prot	tected health information that m	Practices describes the types of uses and ight occur in my treatment, payment for	services. UI	coming appointment, please complete the	NBI	uo	
Insurance Portab		Preventire · Restorative · Coo			or in the performance	of office health care operations.	. The Statement of Privacy Practices also f this office with respect to my protecte		closed packet of forms and bring with you to	RALPH G STENB d, WA 98056 fice	mat	
issues relations to health information					posted in the facility.				ur appointment.	802 802		
your written cons		FINANCIAL			ge the privacy practices that are describe					A 9	d Infor	
information to an				hange. I will be offered a copy of the revise				revised	Patient Registration/Medical History Forms	DDS RALI mwood, WA office	Insurance Primary Denta Insurance Carri Group Plan # Phone # Insured's Name Relation Date of Birth	
Our offices and e	we are committed to providin available. In our process of d	ng you with the highest quality de loing so, we have formulated a fir	Your Rights as	our Patient sit after the revisions become effective. requesting that one be mailed to me.				. I may	Fill out completely, front and back. Bring your		an v D v D v D v D v D v D v D v D v D v	
trained to make c	options to choose from, in own	ler to meet your financial needs		requesting that one of maneut to me.					dental insurance card(s) to your appointment.		SUI mar mar urar one p one p atio atio	Stephen R. Lee, DDS
privacy policy and confident that you	DENTAL INSURANCE:		You have a rig variety of form					(Geolie		HEM D	In Pris Pris Pris Pris Pris Pris Pris Pris	Joseph Van Mieghem, DDS
released.	Our office is happy to coop	6	have disclosed	0				2)	Acknowledgement of Receipt of Statement of	MIEGHEM DDS suite G Lymwoo		Ralph G. Stenberg, DDS
Collecting Protec	responsibility to inform us you "READ YOUR POLI	/ !	requests must If you believe	be STEPHEN R LEE DDS JOSEPH VAN MIEGHEM DDS RALPH G STENBERG DDS				NO	Privacy Practices	MI Suits		
	imposed. Please call your in	Preventive · Rostanative · Connectic · .	also notify the					NO	Fill out, sign, and date after reading Statement of	SEPH VAN N "Avenue W Su "Clcome	M	19718 68th Avenue W, Suite G
We will only requ	with optimal treatment, eac to your insurance plans ber			1 / ?	/ ? Welcome to our office				Privacy Practices	Hd Hd	ay's a	Lynnwood, Washington 98036 PHONE: (425) 778-6677
care, implement p with the law. Thi	for).	Medical history for: Patient Name	Please ask if yo information.	ou Promine + Rostantine + C			eser	entative	Financial Policy	SE Aw	Tod	FRONE (425) 778-6677 FAX: (425) 774-1258
Number, employr	All incurred charges are ult	Are you allergic to any of			annu zanity				Financial Foncy	1 Of K		www.lynawood-edwardedaasia
information will b deemed necessary	insurance company negotia	LatexPenicillinAn medication not listed?		Le About You Patient Name	Today's Date	Insurance Inform Primary Dental Insuran		thority	Please read, sign and date			
protected to the fi	benefits are paid or your co pays on a dental procedure			Patient Name			ice					
Distance	up with your insurance con	Have you ever had a react Explain reaction:		Last	First M	Insurance Carrier			PHONE: (425) 778-6677	PATIENT		
Disclosure of you	however, all balances not p	HAVE YOU BEEN HOS		What You Prefer Birthdate	to be Called	Group Plan # Phone #				Date	Time	
As stated above, v	PAYMENT OPTIONS:	For What Condition?		Social Security #.	Age	Insured's Name			www.lynnwood-edmondsdentist.com	Date	Tone	
information to lav will not use your i	For your convenience, we a	Please check yes or no to		Mailing Address .		Relation Date of Birth				Date	Tour	
use and/or disclos	Personal check (must be in			City	State Zip	Insured's SS#				Date	times for you. To avoid a concellation for	
including voice m	The following is available f	Heart Attack Stroke		Home Phone # Work Phone #		Insured's Employer				please give as 2 business da	gennetiae if you cannot keep these appointments.	
Any breach in the	1. 3 month Payment Plan	Heart Surgery		Cell Phone #		Secondary Dental Insur-		_				
acquisition, access established by the	be charged on same date in	Angina / Chest Pain Heart Murmur		e-mail Address				_				
information relati	imprinted with your persor 2. Interest free payment p	Pacemaker / Defibrillator		Referred By		Insurance Carrier						
	members to discuss this opt	Congenital Heart Defect Artificial Valves		Employer		Group Plan # Phone #						
	Payment options availa information.	Mitral Valve Prolapse		How Long?		Insured's Name						
	information.	High / Low Blood Pressure		Employer's Addre	ess	Relation Date of Birth		POIP Receder # 1417135	1			
	During Street	Allergies		City	State Zip	Insured's SS#						
	Patient Signature	Asthma Breathing Problems		Occupation		Insured's Employer						
		Respiratory Disease										
		Sinus Problems Tuberculosis TB		Status: Single?	Married Divorced Widowed	In Event of Emer	gency					
	(425) 778+667			Spouse's Name		Who should we contact?						
		Eating Disorders		Do you have children	? Yes No How many?	Relationship:				Welcon		
		Drug / Alcohol Abuse				Home Phone #			the second s	VVelcon	ne	
		Tobacco Use		Account Inf	ormation	Work Phone #						
		Please list any medical co		Person responsib		Who is your MEDICAL	DR.?					
				Name		M.D.'s Phone #						
		Please list any medication		Relationship								
				Billing Address						1		
		Have you ever taken the d	City		State Zip					\cap		and the second
		Please rate your general her Are you pregnant? Yes	alth from 1 to 10 (with 10 bei No	Social Security #_						1 !		
				Drivers License #						000	>	
		Signature	(i	if p: Work Phone # Home Phone #					Pre	ventive - Restorative - Cosmetic	Dentistry	
						Please continue	on back ->					