Bellevue IMPLANT & COSMETIC DENTISTRY

Welcome to Bellevue Dental – Tell Us about Yourself

Name: _____ Preferred Name: _____

First Last MI Title

❑Male ❑Female ❑ Transgender SSN: _____ DOB:_____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Domestic Partner

Address: _____ City _____ State _____ ZIP_____
Home Phone: _____ Work Phone: _____
Cell Phone:_____ Email Address: _____
Employer:_____ Occupation: _____
How did you hear about or who referred you to our office?_____
Do you prefer to be contacted for appointment confirmation via email or phone? _____ *(Please circle preference)*

■Insurance – Primary ■

Subscriber Name: _____Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____ Address:_____
Insurance Company Phone: _____Group Number: _____

■Insurance – Secondary ■

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name_____ Address:_____
Insurance Company Phone: _____ Group Number: _____

■Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Bellevue Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Relationship_____Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature:_____ Date: _____

Bellevue IMPLANT & COSMETIC DENTISTRY

Medical History Form

Name: _____ Gender_____ Date of Birth_____
Your current physical health is: ❑ Good ❑ Fair ❑ Poor Height_____ Weight_____

Do you have a personal physician? ❑ Yes ❑ No Physician's Name:_____

Physician's Phone: _____ Date of last visit: _____

Are you currently under the care of a physician? ❑ Yes ❑ No Please explain: _____

Do you use tobacco in any form? ❑ Yes ❑ No If yes, how often_____

Do you have history of alcohol or drug abuse? ❑ Yes ❑ No _____

Have you taken Fosamax, Boniva, and Actonel, Zometa or any other medications containing bisphosphonates? ❑ Yes ❑ No Please list each one: _____

Are you taking any medications? ❑ Yes ❑ No Please list each one:

_____

_____

_____

YesNo **If Female, Please Answer**
❑❑ Are you taking Birth control pills?
❑❑ Are you pregnant? If so, # of Weeks___
❑❑ Are you nursing?
When is your last menstrual period _____

Have you ever had any surgical procedures? ❑ Yes ❑ No _____
please list each one: _____

Have you or your family members ever had any difficulties with anesthesia? ❑ Yes ❑ No _____

YesNo Conditions	YesNo Conditions	YesNo Conditions	YesNo Conditions
❑❑ Abnormal Bleeding	❑❑ Diabetes	❑❑ Heart Surgery	❑❑ Radiation Therapy
❑❑ Alcohol Abuse	❑❑ Difficulty Breathing	❑❑ Hemophilia	❑❑ Rheumatic Fever
❑❑ Allergies	❑❑ Drug Abuse	❑❑ Hepatitis A	❑❑ Sexually Transmitted Disease
❑❑ Anemia	❑❑ Emphysema	❑❑ Hepatitis B	❑❑ Seizures
❑❑ Angina Pectoris	❑❑ Epilepsy	❑❑ Hepatitis C	❑❑ Sickle Cell Disease
❑❑ Arthritis	❑❑ Facial Surgery	❑❑ High Blood Pressure	❑❑ Sinus Problems
❑❑ Artificial Heart Valve	❑❑ Fainting Spells	❑❑ Joint Replacement	❑❑ Shingles
❑❑ Asthma	❑❑ Fever Blisters	❑❑ Kidney Problems	❑❑ Stroke
❑❑ Blood Transfusion	❑❑ Frequent Headaches	❑❑ Liver Disease	❑❑ Thyroid Problems
❑❑ Cancer	❑❑ Glaucoma	❑❑ Low Blood Pressure	❑❑ Tuberculosis
❑❑ Chemotherapy	❑❑ Heart Attack	❑❑ Mitral Valve Prolapse	❑❑ Ulcers
❑❑ Congenital Heart Defect	❑❑ Heart Murmur	❑❑ Pace Maker	❑❑ Other not listed above
❑❑ Colitis	❑❑ HIV+ AIDS	❑❑ Psychiatric Problems	_____
❑❑ COPD			

Are you allergic to any substances listed here? Please check. ❑ None I am aware of ❑ Aspirin ❑ Codeine ❑ Novocain ❑ Lidocaine❑ Erythromycin❑ Penicillin❑ Latex❑ Metals❑ Sulfa Drugs ❑ Benzodiazepine❑ Jewelry ❑ Other, please list_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____ Reviewed by _____

Notes_____

Bellevue IMPLANT & COSMETIC DENTISTRY

Dental History

How may we help you today? _____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you require antibiotics before dental treatment? ❑ Yes ❑ No If yes, why_____

Are you currently in pain? ❑ Yes ❑ No Please explain _____

Have you ever had gum treatment? ❑ Yes ❑ No If yes, when_____

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No _____

Are you under stress? (new job, moving, relationships) ❑ Yes ❑ No _____

Do you like your smile? ❑ Yes ❑ No Please explain _____

Is there anything you would like to change about your smile? ❑ Yes ❑ No _____

Are you happy with the color of your teeth? ❑ Yes ❑ No _____

Do your gums bleed? ❑ Yes ❑ No How many times do you: floss/week?_____ brush/day?_____

Are your teeth sensitive to heat, cold or anything else? ❑ Yes ❑ No Have you lost any teeth? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning? _____ When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit?_____

Here at Bellevue Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

❑ In Office Tooth Whitening ❑ Veneers ❑ Invisible Braces ❑Traditional Orthodontics (Brackets) ❑Smile Makeover ❑Bonding ❑ Sealants ❑ Crown and Bridge ❑Implant Crowns ❑Partials/Dentures ❑Night/Sport Guards ❑Sedation Dentistry ❑Implant Supported Dentures ❑Wisdom Teeth Removal

Consent For Services

I authorize Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.

The Doctor will advise me of the alternatives, benefits, risks and complications to the proposed treatment or procedure and the importance of returning for the follow up appointments that may be necessary to complete the procedure. Failure to do so may cause future dental emergencies or tooth loss.

I also understand that the treatment plan explained is an elective procedure and that there are other forms of treatment available, including the option of no treatment.

I understand that during treatment it may be necessary to change procedures or add procedures because of unforeseen conditions that may arise while working on the teeth that were not found during examination and may require a referral to a specialist. I authorize the doctor and any associates to perform such procedures when in their professional judgment, the procedures are necessary.

I understand that the medications, drugs, anesthetics, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I further understand that drugs and anesthetics may cause unanticipated reactions, which might require medical treatment. I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to operate any vehicle or machinery until I have fully recovered from the effects of the medications.

I authorize Doctor to perform all recommended treatment mutually agreed upon by me and the use of appropriate medication and therapy indicated for such treatment. I further authorize and consent that Doctor chose and employ such assistance as he deems fit.

Please do not hesitate to ask the doctor or the staff if you have any questions.

Print Name of Patient, parent or guardian Date

Signature

HIPPA Consent Form

I understand that as part of my dental care, this office originates and maintains dental records describing my health history, examination and test results for oral health, diagnoses, treatment, and any plans for future dental care or treatment. I understand that this information serves as:

- A basis for planning my dental care and treatment
- A means of communication among the many other health professionals who contribute to my care
- A source of information for applying my dental information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine dental care operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the office has already taken action in reliance thereon.

I request the following restriction to the use or disclosure of my health information:

_____

I also authorize Bellevue Dental can discuss my dental records including treatment, diagnosis, financial, scheduling, etc with the following individual(s)_____

_____ _____ _____

Signature of patient, parent or legal guardian. Name (Print) Date

Date Notice Effective Date or Version: 12/2008

Rescheduling Policy

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic." Appointment time is reserved for you. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it. **If you do not show up to your appointment or cancel without 24-hour notice we reserve the right to dismiss the patient for future scheduling or a no-show/cancellation charge will apply**. We limit giving you a warning the first time. Thank you for your cooperation and understanding this helps us to treat our patients with the care and attention they need at their individual appointments.

Financial Policy

Our goal through your examination, diagnosis, and treatment phases is to provide you with the best possible oral health care. We recommend to you those treatments that we believe you need and we will discuss alternative plans with you. We provide only as estimate of insurance coverage and patient payments are due at the time of service. **We cannot guarantee payment by your insurance company. Regardless of any estimate given you are ultimately responsible for payment and keeping your account current**. In an attempt to keep costs down, we do not accept personal checks. We will gladly accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, Care credit and cash at the time of service.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of benefits.

Patient, Parent or Guardian Signature: _____

Printed Name of Patient, Parent or Guardian: _____

Today's Date:_____