BELLEVUE WELLNESS DENTAL/PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME_____**FIRST**_____**MI**_____ **DATE:**_____

(√) □ **MARRIED** □ **SINGLE** □ **MINOR** **(√)** □ **MALE** □ **FEMALE**

DOB _____/_____/_____ **SSN#**_____-____-_____ **(required)**

ADDRESS_____**APT**_____**CITY**_____**ZIP**_____

PHONE: HOME (_____)_____-_____ **CELL** (_____)_____-_____ **WORK** (_____)_____-_____

EMAIL ADDRESS:_____@_____

(√ PREFERRED CONTACT) □ **HOME** □ **CELL** □ **WORK** □ **EMAIL**

HOW DID YOU HEAR ABOUT US?_____**WHO CAN WE THANK FOR REFERRERING YOU?** _____

EMPLOYMENT/INSURANCE

NAME OF EMPLOYER:_____**EMPLOYER ADDRESS**_____

PERSON RESPONSIBLE FOR ACCOUNT (√ ONE) □ **SELF** □ **SPOUSE** □ **GUARDIAN** □ **FATHER** □ **MOTHER**

□ **OTHER,** _____**RELATIONSHIP**_____

INSURANCE INFORMATION:

DENTAL INSURANCE: GIVE DENTAL/MEDICAL INSURANCE CARDS TO FRONT DESK TO SCAN INTO CHART

PRIMARY INS (Self or info for Responsible party)	SECONDARY INS (Self or info for Responsible party)
Last_____First_____MI___	Last_____First_____MI___
Address_____Apt_____	Address_____Apt_____
City_____St_____Zip_____	City_____St_____Zip_____
DOB_____/_____/_____ Relationship to Pt_____	DOB_____/_____/_____ Relationship to Pt_____
Dental Ins Co_____	Dental Ins Co_____
Ins Phone #(_____)_____	Ins Phone #(_____)_____
Subscriber#(may be SS#)_____Group #_____	Subscriber#(may be SS#)_____Group #_____
Plan Name (if Known)_____	Plan Name (if Known)_____
EMPLOYER:_____	EMPLOYER:_____

MEDICAL INSURANCE: (SOME PROCEDURES CAN BE BILLED TO YOUR MEDICAL INSURANCE)

PRIMARY INS (Self or info for Responsible party)	SECONDARY INS (Self or info for Responsible party)
Last_____First_____MI___	Last_____First_____MI___
Address_____Apt_____	Address_____Apt_____
City_____St_____Zip_____	City_____St_____Zip_____
DOB_____/_____/_____ Relationship to Pt_____	DOB_____/_____/_____ Relationship to Pt_____
Dental Ins Co_____	Dental Ins Co_____
Ins Phone #(_____)_____	Ins Phone #(_____)_____
Subscriber#(may be SS#)_____Group #_____	Subscriber#(may be SS#)_____Group #_____
Plan Name (if Known)_____	Plan Name (if Known)_____
EMPLOYER:_____	EMPLOYER:_____

EMERGENCY CONTACT: Name_____ **Phone:** (_____)_____
Address:_____ **City/State/Zip**_____
Relationship:_____

METHOD OF PAYMENT: PAYMENT IS EXPECTED ON DATE OF SERVICE

AUTHORIZATION: I hereby authorize payment directly to BELLEVUE WELLNESS DENTAL of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of received dental treatment. I authorize Bellevue Wellness Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as necessary for proper dental care. The information written on this form is correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other pertinent information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

_____

Signature of patient or responsible Party **Date**

Patient Name _____ Birth Date_____

HEALTH HISTORY

PRIMARY REASON FOR VISIT: □ Regular Exam □ Emergency Exam or Focused Exam □ Consultation

DENTAL HISTORY

Do you have a specific dental concern(s)? If so describe:_____
Do you have concern(s) about your smile? If so describe:_____
Date of your last dental exam_____ Date of your last cleaning_____

MEDICAL HISTORY

Are you under a physicians care now?_____Why?_____
Any specialist care? (i.e. Cardiologist) _____Physician Name:_____
Contact #_____
Have you ever been hospitalized or had major surgery in the last 3 years? If so, explain _____
_____
Have you ever had a serious injury to your head or neck? If so, explain_____
Have you ever had facial/jaw/TMJ surgery? If so, explain_____
Do you have any joint replacement(s)_____Year of surgery_____
Do you have a pacemaker? YES NO
Do you have a stent or artificial heart valve? YES NO Year of placement_____

MEDICATIONS/ALLERGIES (Circle or Check appropriate answers)

Are you taking any of the following medications? (Please check all that apply)

□ Coumadin/Warfarin □ Plavix □ Aspirin □ St. John Wort

YES	NO	Do you take or have a history with recreational drugs?
YES	NO	Do you take over the counter medications? Please list:_____
YES	NO	Do you take natural remedies? Please list:_____
YES	NO	Do you smoke cigarettes, cigars or have a smoking or chewing tobacco history?_____

Please list other medications or provide attached list:

YES	NO	Do you have allergies?

Are you allergic to any of the following (Please check all that apply)?

□ Latex □ Penicillin (of any form) □ Codeine □ Local Anesthetic □ Acrylic □ Metal
□ Other Allergy:_____

DO YOU EXPERIENCE ON A REGULAR BASIS: (ALL MUST BE ANSWERED)

YES	NO	Cold sores or fever blisters?	YES	NO	Bleeding problem, bruise easily?
YES	NO	Canker sores or mouth sores?	YES	NO	Sinus problems?
YES	NO	Swollen Ankles?	YES	NO	Difficulty swallowing?
YES	NO	Shortness of breath?	YES	NO	Diarrhea, constipation, blood in stools?
YES	NO	Chest Pain?	YES	NO	Frequent vomiting, nausea?
YES	NO	Persistent cough, coughing up blood?	YES	NO	Difficulty urinating, blood in urine?
YES	NO	Dizziness?	YES	NO	Ringing in ears?
YES	NO	Headaches?	YES	NO	Fainting spells?
YES	NO	Blurred vision?	YES	NO	Seizures?
YES	NO	Excessive thirst?	YES	NO	Dry mouth?
YES	NO	Jaundice?	YES	NO	Joint pain, stiffness?

Patient Name _____ Birth Date_____

DO YOU HAVE OR HAVE YOU EVER HAD: (ALL MUST BE ANSWERED)

YES	NO	Heart attack, heart defects?	YES	NO	Tumors, cancer?
YES	NO	Heart murmurs?	YES	NO	Arthritis, rheumatism?
YES	NO	High Blood Pressure?	YES	NO	Eye disease?
YES	NO	Stroke, hardening of arteries	YES	NO	Skin Disease?
YES	NO	Rheumatic Fever?	YES	NO	Anemia?
YES	NO	Asthma, TB, emphysema?	YES	NO	VD (Venereal Disease: syphilis or gonorrhea)?
YES	NO	Recent weight loss, fever, night sweats?	YES	NO	Other STD?
YES	NO	Hepatitis □ A □ B □ C	YES	NO	Diabetes

YES NO Do you have or ever had any other disease or medical problems not listed on this form?
If so, please explain:_____
_____
_____

WOMEN ONLY:

YES NO Are you using birth control pills?
YES NO Are you pregnant or might be pregnant? How many weeks?_____
YES NO Are you nursing?

I have completed the above medical History to the best of my knowledge. I have answered the questions on this form accurately and honestly. I understand that providing incorrect or incomplete information can be harmful to my (or the patient I am responsible for's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____
Signature of patient, parent or guardian **Date**

_____ _____
Reviewed by Dr. (signature)

Significant history notes or comments by doctor

Patient Name _____ Birth Date_____

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The OralID examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID™ to reduce the mortality of late stage detection.

Our office charges a $20.00 co-pay per screening with the OralID. We will attempt to bill your insurance. You will only be responsible for an additional co-pay if the fluorescence screening dictates that a brush biopsy is needed.

☐ Yes, I request that your staff perform an examination with the OralID. I accept financial responsibility for this examination.

_____ _____ _____

Signature Name Date

☐ No, I prefer to not have this examination at this visit.

_____ _____ _____

Signature Name Date

Patient Name _____ Birth Date_____

BELLEVUE WELLNESS DENTAL

Vital Information about your Dental Insurance

Our office is happy to file your insurance to receive the dental benefits that you and your employer are paying premiums for. Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts they pay toward your dental on the restricted fee schedules related to premium payments and geographical location, In other words, ***your insurance plan will pay a set amount for each service, regardless of what the dentist's fee might be.*** Deductibles and co-payments are typically built in to most plans and state law strictly regulates their required payment. Both our office, and you as the policy beneficiary, can be prosecuted if deductibles and co-payments are not collected, Your Employee benefits director can usually help you become familiar with your plan and its' restrictions, and our office will assist you in maximizing your benefits to the best of our ability.

Our responsibilities

1. Complete your insurance claim forms and submit them to your carrier.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance a second time within a 60 day period.

Your responsibilities:

1. To pay fees not covered by your plan at the time of treatment.
2. To provide our office with necessary information concerning your insurance Coverage. This allows correct filing of claims.
3. To update my insurance with Bellevue Wellness Dental if my plan changes
4. To understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay!

We thank you for choosing our office and will do all we can to help you obtain the benefits you deserve. Please sign the form below. We will keep it in your records.

_____ _____

Patient or Insured **Date**

Patient Name _____ Birth Date_____

Bellevue Wellness Dental

Important Information for our Patients

1. **Notice of Privacy Practices - Acknowledgement**
We keep records of your health care services that we have provided for you. You are entitled to view and request copies of your dental records at any time. We will not disclose your records to others unless you direct us to or the law authorizes or compels us to do so. Our copy of the Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. Please ask the front desk if you would like a copy of the Privacy Practice Laws.

2. Insurance companies do not cover cancelled or missed appointment fees. We appreciate notice of cancellation 24 hours prior to your appointment to avoid a missed appointment fee of $60.00.

3. Our office charges a $25.00 fee for all returned checks.

4. All patient x-rays can be released with a signed authorization form,

5. Any appointment over 2 hours requires a deposit to hold the appointment time. The deposit will be used towards treatment in the amount of 20% or $75

Payments and accepted Method of Payment

All **ESTIMATED** co-pays are due the date the services are rendered. We accept cash, checks, money order and all major credit cards. Checks are only accepted from patients of record. New Patients must pay by cash or credit/debit cards.

We do have financial options. You are welcome to inquire about them with any of the front office staff.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices and I have read and understand the above patient information.

X_____ Date _____
Patient or Parent/ Legal Guardian Signature

X_____
Printed Name if signed on behalf of the patient Relationship to Patient

Patient Name _____ Birth Date_____

Upgrade Notification
(For patients with dental insurance)

Bellevue Wellness Dental is committed to provide the best possible dental treatment to our patients. For this reason, we routinely do not use amalgam (silver) filling material. The material we used for restorations is a composite (white) material. THIS IS OUR STANDARD OF CARE. Depending on your insurance coverage, you may be responsible for the difference between the white restorations and the silver restoration if your insurance downgrades to the amalgam (silver) restoration fee. If you would like to have amalgam restorations please let the dentist or one of the office staff know **before** treatment is performed.

Additionally, unless otherwise requested by our patient, we routinely make Porcelain fused to gold (PFG) crowns. Some insurance will downgrade molar crowns (posterior teeth) to all metal crowns fees. This is a downgrade from the porcelain fused to metal crowns (While colored). Depending on your insurance coverage, you may be responsible for the difference between the PFG and the metal crown. ***IF YOU DO NOT WANT THIS UPGRADE PLEASE INFORM DR.CHEN OR DR. HSIEH. YOU CAN ALSO INFORM ONE OF THE STAFF BEFORE THE PROCEDURE.***

If you would like further information, feel free to discuss this with any of our dentists or staff.

I have read the above notification and understand that I will be receiving upgraded services. I also understand that I may be responsible for the difference in fees for these upgraded services that is not covered by my insurance.

_____ _____

Patient (Parent if patient is a minor) Date

Electronic Communication

Bellevue Wellness Dental confirms appointments using text messages and/or email. We also send continuing care reminders (exam and cleaning) by email. If an appointment is not made with the 1st email, a post card will be sent to your home. These reminders are sent 1 month before you are due.

Please note: If you confirm your appointment with the first reminder, you will not receive any additional text reminders. You will still receive emails.

You also have the ability to look at your own account by registering at www.bellevuewellnessdental.com You will be able to view you and your family's information such as if insurance paid, if we received a payment, when you are due for your next exam, and appointment you have scheduled.

You can choose how you want to be reminded.

I want to receive email appointment and continuing care reminders. (Continuing care reminders are sent to let you know when you are due for your next cleaning appointment)

□ **Yes** □ **NO**

If yes for email, what is your preferred email address?

@

I want to receive text appointment reminders.

□ Yes □ NO

PLEASE NOTE: BELLEVUE WELLNESS DENTAL CONFIRMS BY TEXT AND/OR EMAIL MESSAGES. IF YOU ANSWER "NO" TO ANY OF THE OPTIONS THEN YOU ARE RESPONSIBLE FOR REMEMBERING YOUR APPOINTMENT DATE AND TIME. FAILED APPOINTMENTS ARE SUBJECT TO A $75 FEE.

I acknowledge that I have options that can be changed at any time.

_____ _____

Patient, parent or guardian signature Date

Patient Name _____ Birth Date_____

Privacy Practices

Our office is dedicated to protect the rights of our patients and the confidential information entrusted in us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. 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 health care operations. Your personal health information will never be given to anyone without your written consent. You may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health 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 of 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. We will never use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, electronic mail, world wide web, and postal mail.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in many formats; and to request a list of instances in which we, or our businesses associates, have disclosed your protected information for used other than state above. All such request 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 so that we may take appropriate action.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.
- I have received, read, and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time 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 much private information is used, or disclosed, to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____ Date:_____

Relationship to Patient: _____