Bellevue Specialized
Dental Care

PATIENT'S INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____ Driver's license #: _____ State: _____

SS #: _____ Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone #: _____ Emergency phone # (other than spouse): _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____ _____

Bellevue Specialized Dental Care

PATIENT'S DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT _____		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

Bellevue Specialized Dental Care

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM: _____		
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____		
5 ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	☐	☐
6 HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____		
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	☐	☐
8. HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
9. DO YOU BRUISE EASILY	☐	☐
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS	☐	☐
12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX	☐	☐
13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES?		
14. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LAVITRA IN THE LAST 24 HOURS?		
15. DO YOU USE TOBACCO		
16. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES		
17. ARE YOU WEARING CONTACT LENSES		
18 DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)		
19. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT		

WOMEN ONLY:

	YES	NO
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX / RUBBER	☐	☐
OTHER (PLEASE LIST) _____		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐

	YES	NO
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
EATING DISORDERS	☐	☐

Bellevue Specialized
Dental Care

FINANCIAL ARRANGEMENTS

We would like to thank you for selecting our dental team to help you improve and maintain your dental health. We enjoy what we do and are grateful for the opportunity to serve you.

We have adopted the following payment policy:

- We accept cash, personal check, Visa, Master card, and debit cards.
- Any patient (with insurance or not) that cancels his appointment with less than 48 hours will be charged with $75.00. In case of a hygiene or perio appointment, there will be an additional charge of $100.00 put into your account. There will be no exceptions. This charges, are not covered by any insurance. This amount will have to be pay before we can continue with any existing dental treatment.

PLEASE NOTE: Any and all charges incurred for dental services provided are the responsibility of the patient or guarantor of the patient, regardless of any type of third party (i.e. dental insurance). Any account balance still owing after 60 days from date of service will be assessed a finance charge of 1.5% monthly (18% annual) regardless of delayed, denied, or partial insurance coverage.

We will be happy to bill your dental insurance *as a courtesy* provided that you bring your insurance card with you to your visit. You may also submit insurance claims yourself. We must emphasize that as dental care providers, our relationship is with you, not your insurance company, with whom we have no legal relationship. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Please feel free to contact us and we will be happy to discuss any financial concerns you might have.

Dr. David Aronowitz and Staff

_____ _____

Patient Signature Date

David Aronowitz, M.S.D.
Bellevue Specialized Dental Care
15700 Bel-Red Road Bellevue, WA 98008
425-881-8448

STATEMENT OF PRIVACY PRACTICES

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

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 health 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 state 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 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 appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other that stated above. All such 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 can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at Bellevue Specialized Dental Care. Please let us know if you have any questions concerning your privacy rights at the protection of your personal health information.

Patient's Name: _____

I reviewed Bellevue Specialized Dental Care's Statement of Privacy Practices, which provides information about how my health information may be used and disclosed.

_____ _____

Patient / Guardian signature Date

Patient Name: _____ David Aronowitz, DDS, MSD Bellevue Specialized Dental Care

SPECIAL CONSENT AND RELEASE FORM FOR TREATMENT

I understand that the expected results of said treatment cannot always be guaranteed. If I desire I can discuss, to my satisfaction the following:

1. Dr. Aronowitz performs General Dentistry, Orofacial Pain/TMD and Oral Medicine and IV Sedation. I fully understand I must inform about my medical condition, including medication and allergies (latex, sodium bisulfate, food, etc) during the exam, and inform if any changes happened during my dental treatment. I fully understand that any omission of information could represent a risk during and after my treatment at BSDC. If you are pregnant, nursing or want to become pregnant please inform us.

2. I understand that adverse drug reaction could happen to anyone including a healthy patient. Local anesthetics are drugs.

3. I provided information about ASTHMA, if any: Type (allergic/non-allergic), last asthma attack, medications, triggers, etc., ANEMIA of any kind and METAGLOBULINEMIA. I will report Dr. Aronowitz upon arrival if I do not feel well, or any important reason to postpone the treatment.

4. If medical conditions are present I allow Dr. Aronowitz to have a consultation with my primary physician, order blood tests or other exams when needed. In severe medically compromised cases I consent that Dr. Aronowitz may refer me to a hospital or hospital dental clinic.

5. I understand that reaction to stress, local anesthetics, medical condition and medications are unique for each patient.

6. Medical emergencies in the dental office are rare but could include: Unconsciousness, respiratory distress, airway obstruction, hyperventilation, bronchospasm, heart failure, altered consciousness, seizures, MI, CVA, drug related emergencies, chest pain, cardiac arrest. In case I develop a life threatening condition after a dental procedure while at home I should call 911, in the situation is not life threatening I should call the office at 425.881.8448.

7. Local anesthetics might be used and although complications or adverse reactions are rare, these include: Needle breakage, persistent anesthesia or paresthesia, facial nerve paralysis, trismus, soft-tissue injury, hematoma pain on injection, burning on injection, infection, edema, sloughing of tissues, post-anesthetic intraoral lesion, etc. If a feel sick during or after the use of anesthetics I should inform Dr. Aronowitz as soon as possible.

8. When Oral Sedation (Valium, Halcion, etc), Inhalation Sedation (Nitrous Oxide) and IV Conscious Sedation is to be used, I must be accompanied by a designated driver. Dr. Aronowitz could deny treatment if designated drive is not present.

9. Vital signs might be taken prior to dental procedure involving local anesthetics and other drugs. If anything is abnormal Dr. Aronowitz will discuss it with me and the appointment might be rescheduled.

10. Local anesthetics usage varies from patient to patient, type of procedure, area of injection, etc. Multiple attempts to anesthetize an area might be needed. Duration varies from 30 min to 10 hours.

11. When an infection is present local anesthetics might not be 100% affective. Treatment might need to be rescheduled and antibiotics and/or other medications will be prescribed.

12. Additional x-rays and clinic photographs might be necessary for documentation, insurance or treatment purposes, etc.

13. If a procedure cannot be performed at the office you might be given a referral for a specific procedure.

14. After selective procedures I will be provided with an emergency cell phone number. I agree to use it ONLY for emergencies related to that procedure.

15. Questions concerning financial information will be answered by the office manager, THEY WILL NOT BE ASWERED BY DR. ARONOWITZ.

16. As a matter of office policy, at least 1 staff member will be present with a patient.

17. I understand that no treatment will be performed =until this consent is understood and signed. I understand that I am free to withhold or withdraw consent to the proposed treatment at any time.

Patients/Guardian Signature: _____ Date:_____

Bellevue Specialized Dental Care

RELEASE OF RECORDS

The release of Dental /Medical Records is requested for:

Patient's Name: _____ Date of Birth: _____ Phone: _____

Signature: _____ Date:_____
Patient, Parent, or Legal Guardian Signature

Facility Releasing Records:

Name: _____ Phone: _____ Fax: _____

Address: _____

Records include dental/medical history, x-ray findings. diagnosis, prognosis and access to all hospital records and photocopies of the same.

Please forward the records promptly by fax email or mail to:

Bellevue Specialized Dental Care
3006 Nortup Way , Suite 102
Bellevue, WA 98004
425.881.8448
Fax: 425.881.0355
email: info@bellevuesdental.com

Authorization was received for the above patient by:

Employee: _____ Date: _____ Time:_____

Records released:_____

Bellevue Specialized Dental Care

3006 Northup Way, Suite 102
Bellevue, WA 98004

Directions:

From Seattle:

1. Merge onto I-5 N via the ramp on the left toward Vancouver B.C.
2. Merge onto WA-520 E via EXIT 168B toward Bellevue/Kirkland.
3. Take the exit toward Lake Washington Boulevard Northeast
4. Turn right onto Bellevue Way NE
5. Take the 1st right onto Northup Way

Our office will be on the left.

From WA-520 East.

1. Merge onto WA-520 W via the ramp to Seattle.
2. Take the 108th Ave NE exit.
3. Turn right onto 108th Ave NE.
4. Take the 1st right onto Northup Way.

Our office will be on the left.