Family Dentistry *of* Bellevue

PATIENT INFORMATION

Welcome to our practice!
This confidential information will help us prepare for your visit.

NAME ◯ MRS ◯ MR ◯ MS ◯ REV ◯ DR			I PREFER TO BE ADDRESSED AS
BIRTHDATE	SS #	EMAIL	
ADDRESS	CITY	STATE	ZIP CODE
I AM ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯ SEPARATED			WHOM MAY WE THANK FOR REFERRING YOU?
HOME PHONE #	CELL PHONE #	WORK PHONE #	
EMPLOYER ADDRESS	EMPLOYER NAME	OCCUPATION	

We may use an automated appointment reminder system that can send you convenient email, text messages, and/or postcards. We may also call and if necessary leave brief voicemail messages.

If you would prefer **NOT** to receive routine reminders from us via certain methods, please indicate below:

☐ NO TEXT MESSAGES ☐ NO EMAILS ☐ NO CELL PHONE ☐ NO HOME PHONE ☐ NO WORK PHONE ☐ NO POSTCARDS

FAMILY MEMBERS SEEN AS PATIENTS HERE			
SPOUSE'S NAME			SPOUSE'S BIRTHDATE
SPOUSE'S SS#	SPOUSE'S CELL PHONE #	SPOUSE'S WORK PHONE #	
SPOUSE'S EMPLOYER ADDRESS	SPOUSE'S EMPLOYER NAME	SPOUSE'S OCCUPATION	
EMERGENCY CONTACT	EMERGENCY CONTACT PHONE #	EMERGENCY CONTACT RELATIONSHIP	
PERSON FINANCIALLY RESPONSIBLE ◯ SELF ◯ SPOUSE ◯ OTHER	RESPONSIBLE PARTY NAME (IF OTHER)	RESPONSIBLE PARTY PHONE # (IF OTHER)	RESPONSIBLE PARTY SS # (IF OTHER)
RESPONSIBLE PARTY ADDRESS (IF OTHER)			RESPONSIBLE PARTY RELATIONSHIP (IF OTHER)
DENTAL INSURANCE COMPANY NAME	DENTAL INSURANCE COMPANY PHONE #	PATIENT'S ID #	GROUP #
DENTAL INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE

CONCERNS I SEE ABOUT ACHIEVING OR MAINTAINING EXCELLENT DENTAL HEALTH ARE:

☐ I SEE NO OBSTACLES ☐ TIME AWAY FROM WORK OR OTHER OBLIGATIONS ☐ FEAR BECAUSE OF PAST DENTAL EXPERIENCES
☐ COST OF TREATMENT ☐ FEAR OF POSSIBLE DISCOMFORT, PAIN, OR INJECTIONS
☐ OTHER (PLEASE EXPLAIN)

I BELIEVE MY PRESENT STATE OF DENTAL HEALTH IS ◯ POOR ◯ FAIR ◯ GOOD ◯ EXCELLENT	I AM AWARE OF THE CURRENT DENTAL TREATMENT THAT I NEED ◯ YES ◯ NO

Family Dentistry *of* Bellevue

HEALTH HISTORY

Welcome to our practice!
This confidential information will help us prepare for your visit.

PLEASE SELECT ONE

◯ I AM SATISFIED WITH MY SMILE ◯ I AM CURIOUS HOW TO IMPROVE MY SMILE ◯ I AM NOT SATISFIED WITH MY SMILE

MY CURRENT MEDICAL HEALTH IS

◯ EXCELLENT ◯ GOOD ◯ FAIR ◯ POOR

I AM UNDER THE CARE OF A PHYSICIAN

◯ YES ◯ NO

PHYSICIAN NAME

PHYSICIAN PHONE #

PHYSICIAN ADDRESS

PLEASE LIST ALL MEDICATIONS YOU TAKE (INCLUDE BOTH PRESCRIPTION & OVER THE COUNTER)

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING

☐ ANEMIA	☐ COLD SORES	☐ FEVER BLISTERS	☐ HIV/AIDS	☐ SCARLET FEVER
☐ ARTHRITIS	☐ COLITIS	☐ GLAUCOMA	☐ HOSPITALIZED	☐ SEVERE OR FREQUENT HEADACHES
☐ ARTIFICIAL JOINT	☐ DIABETES	☐ HEART ATTACK	☐ KIDNEY PROBLEMS	☐ SHINGLES
☐ ARTIFICIAL VALVE	☐ DIFFICULTY BREATHING	☐ HEART MURMUR	☐ MITRAL VALVE PROLAPSE	☐ SINUS PROBLEMS
☐ ASTHMA	☐ DRUG/ALCOHOL DEPENDENCE	☐ HEART SURGERY	☐ PACEMAKER	☐ STROKE
☐ BLOOD TRANSFUSION	☐ EMPHYSEMA	☐ HEMOPHILIA/BLEEDING	☐ PSYCHIATRIC PROBLEMS	☐ TUBERCULOSIS
☐ CANCER	☐ EPILEPSY/SEIZURES	☐ HEPATITIS	☐ RADIATION TREATMENT	☐ ULCERS
☐ CHEMOTHERAPY	☐ FAINTING	☐ HIGH/LOW BLOOD PRESSURE	☐ RHEUMATIC FEVER	☐ VENEREAL DISEASE

PLEASE CHECK ANY OF THE FOLLOWING DRUGS YOU HAVE USED AT ANY TIME

☐ ACTONEL ☐ AREDIA ☐ BIOPHOSPHONATES/BISPHOSPHONATES ☐ BONIVA ☐ DIDRONEL ☐ FOSAMAX ☐ SKELID ☐ ZOMETA

ARE YOU ALLERGIC TO OR HAVE HAD DIFFICULTY WITH ANY OF THE FOLLOWING SUBSTANCES

☐ ASPIRIN ☐ CODEINE ☐ DENTAL ANESTHETIC ☐ ERYTHROMYCIN ☐ LATEX ☐ PENICILLIN ☐ SULFA ☐ TETRACYCLINE

☐ OTHER (PLEASE LIST): _____

WOMEN ONLY

ARE YOU PREGNANT? ◯ YES ◯ NO ARE YOU NURSING? ◯ YES ◯ NO ARE YOU TAKING BIRTH CONTROL? ◯ YES ◯ NO

PLEASE SELECT ONE

◯ I CURRENTLY HAVE NO DENTAL PAIN, JAW PAIN, OR SENSITIVITY ◯ I CURRENTLY HAVE SOME DENTAL PAIN, JAW PAIN, OR SENSITIVITY

PLEASE SELECT ONE

◯ MY MOUTH IS VERY COMFORTABLE ◯ MY MOUTH IS MODERATELY COMFORTABLE ◯ MY MOUTH IS UNCOMFORTABLE

The information provided is accurate & complete to the best of my knowledge. I authorize the doctor to take X-rays, make study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

Family Dentistry *of* Bellevue

DENTAL HISTORY

Welcome to our practice!
This confidential information will help us prepare for your visit.

DATE OF LAST DENTAL VISIT	DATE OF LAST DENTAL CLEANING	DATE OF LAST FULL MOUTH X-RAYS

PREVIOUS DENTIST NAME	PREVIOUS DENTIST PHONE

PREVIOUS DENTIST STREET ADDRESS	CITY	STATE	ZIP CODE

HOW OFTEN DO YOU BRUSH YOUR TEETH?	HOW OFTEN DO YOU FLOSS?	WHAT OTHER DENTAL AIDS DO YOU USE? (SONICARE, WATERPIK, ETC.)

DO YOU HAVE ANY DENTAL PROBLEMS NOW?
◯ YES ◯ NO

IF YES, PLEASE DESCRIBE:

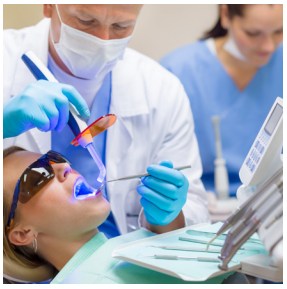
PAST DENTAL TREATMENT (SELECT ALL THAT APPLY)

- ☐ HAD ORTHODONTIC TREATMENT (BRACES)
- ☐ HAD ORAL SURGERY (TYPE_____)
- ☐ BEEN DIAGNOSED WITH OR TREATED FOR PERIODONTAL (GUM) DISEASE
- ☐ DIAGNOSED OR TREATED FOR ORAL CANCER
- ☐ WEAR ANY REMOVABLE DENTAL APPLIANCES (MOUTHGUARD, PARTIALS, DENTURES, RETAINERS)

DENTAL CONDITIONS (SELECT ALL THAT APPLY)

- ☐ TEETH SENSITIVE TO HOT / COLD / BITING / SWEETS
- ☐ JAW CLICKING OR POPPING (WITH / WITHOUT PAIN)
- ☐ TIRED JAW
- ☐ CHRONIC HEAD / NECK / EAR ACHES
- ☐ MUSCLE PAIN IN FACE OR NECK
- ☐ FEEL YOU HAVE CHRONIC BAD BREATH
- ☐ GUMS BLEEDING OR HURTING
- ☐ FOOD ALWAYS CATCHING IN TEETH
- ☐ MOUTH BREATHE WHILE ASLEEP OR AWAKE
- ☐ FEEL LIKE YOUR MOUTH IS ALWAYS DRY
- ☐ HAVE RECURRENT CANKER SORES (INSIDE MOUTH)
- ☐ HAVE RECURRENT COLD SORES (OUTSIDE MOUTH)
- ☐ BITE/CHEW YOUR LIPS OR CHEEKS REGULARLY





PLEASE HAVE DR. MACK PROVIDE ME WITH MORE INFORMATION ABOUT THE FOLLOWING SERVICES:

- ☐ INVISALIGN
- ☐ SLEEP APNEA (Comfortable alternatives to CPAP)
- ☐ WHITENING
- ☐ IMPLANTS
- ☐ VENEERS

I have reviewed this questionnaire and answered its questions accurately and to the best of my knowledge. I understand that the answers I have provided will be used by the doctor to determine appropriate dental treatment. I agree to notify the practice if any health changes occur. I authorize the doctor and dental staff to perform the necessary dental services. I authorize the dental staff to release all information necessary to secure payment of benefits. I authorize my insurance company to pay the doctor directly. I authorize the use of this signature on all insurance submissions. 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. I understand that I am financially responsible for any charges not covered by my dental insurance.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE

Family Dentistry *of* Bellevue

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

THIS NOTICE OF PRIVACY PRACTICES CONTINUES ON NEXT PAGE

Family Dentistry *of* Bellevue

NOTICE OF PRIVACY PRACTICES

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, charges may apply for printing, postage, and time needed to complete the request. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may file your complaint using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Family Dentistry *of* Bellevue

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Note: You may refuse to sign this acknowledgment.

I, _____ have recieved a copy of this office's Notice of Privacy Practices.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ INDIVIDUAL REFUSED TO SIGN
- ☐ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGMENT
- ☐ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGMENT
- ☐ OTHER (PLEASE SPECIFY): _____

SIGNATURE OF OFFICE REPRESENTATIVE	DATE

Family Dentistry *of* Bellevue

FINANCIAL POLICY

Payment is due at the time services are rendered. For your convenience we accept cash, personal checks, money orders, Visa, Mastercard, Discover, and CareCredit. A fee of $30.00 will be added to your account for any checks returned by your bank. If your account is sent to our collections department it will result in an additional $75.00 as a collection fee.

Insurance Benefits are determined by your employer, not your dentist. Insurance is not a guarantee of payment; it will not cover all your costs. Your insurance policy is a contract between you and your insurance company. Payment to Family Dentistry of Bellevue is ultimately your responsibility. We will do our best to maximize all the benefits that you are legally entitled to. As a courtesy we will be glad to file your claim for you. Please provide us with your dental insurance card and required employer information.

Continuity and Consistency of Care are key to maintaining proper dental health. Maintaining a relationship with our patients is our first priority. Individuals who have not been seen within the practice within three years will be considered a new patient to the office. Your appointment is reserved exclusively for you; therefore, courtesy of advance notice when you are unable to keep an appointment is appreciated and required. We reserve the right to charge and collect fees for appointments that are cancelled or broken without 24-hours notice. Providing advance notice allows other patients who may have been waiting for an appointment the opportunity to be seen. We reserve the right to dismiss any patient from the practice who misses or cancels, without 24 hours notice, three or more consecutive appointments. Cancellations with less than 24 hours notice are considered missed appointments. Missed appointments will result in a $50.00 missed appointment fee. Appointment changes must be made directly through the office.

I have been given the opportunity to ask questions regarding this policy. I have read and understand this financial policy.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE