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Bannerwood Cosmetic & General Dentistry

Puneet Aulakh DDS

New Patient Registration

1808 Richards Rd Suite 101 · Bellevue, WA 98005 · Ph: (425) 378-DENT · Fax: (866) 891-3386 · www.factoriadental.com

Patient Information

First Name:

Preferred Name:

Last Name:

☐ Male
☐ Female

Marital Status: Single

Address:

Date of Birth:

SSN:

City, State, Zip

Home Phone:

Work Phone:

Cell Phone:

Employer:

Email:

Who may we thank for referring you to our office?

How do you like to be contacted? Cell Phone

Emergency Contact & Phone:

Responsible Party

Full Time Student: ◯ Yes ◯ No

Name of School: _____

Name of Parent/Guardian/Responsible Party:

Date of Birth:

Relationship to patient (mom/dad/grandma):

Dental Insurance

Primary dental insurance:

Policy Holder:

Date of Birth:

Employer:

Group #:

ID/SSN:

Secondary dental insurance:

Policy Holder:

Date of Birth:

Employer:

Group #:

ID/SSN:

☐ I have no idea how insurance works. Please help explain it to me.

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Medical History

Print Form

Patient Name _____ Date: _____

Do you have or have you had any of the following? Please check "YES" or "NO".

Heart Problems:

- Heart Murmur or Mitral Valve Prolapse..... ◯ YES ◯ NO
- Heart Valve Problem..... ◯ YES ◯ NO
- Artificial Valve..... ◯ YES ◯ NO
- High Blood Pressure..... ◯ YES ◯ NO
- Heart Attack or Stroke..... ◯ YES ◯ NO
- Taking Heart Medications..... ◯ YES ◯ NO

Blood Problems:

- Easy Bruising..... ◯ YES ◯ NO
- Abnormal Bleeding..... ◯ YES ◯ NO
- Take Blood Thinners..... ◯ YES ◯ NO

Asthma, Emphysema or Tuberculosis..... ◯ YES ◯ NO

Sinus Troubles..... ◯ YES ◯ NO

Frequent or Severe Headaches..... ◯ YES ◯ NO

Fainting Spells, Seizures or Epilepsy..... ◯ YES ◯ NO

Glaucoma..... ◯ YES ◯ NO

Bone or Joint Problems

- Joint Replacement (Hip, Pins, Plates, etc)..... ◯ YES ◯ NO
- Implants..... ◯ YES ◯ NO
- Arthritis or Osteoporosis..... ◯ YES ◯ NO
- Taking Corticosteroids..... ◯ YES ◯ NO

Cancer (Chemotherapy or Radiation)..... ◯ YES ◯ NO

Allergic Reactions:

- Aspirin, Acetaminophen, or Ibuprofen..... ◯ YES ◯ NO
- Codeine or Other Narcotics..... ◯ YES ◯ NO
- Dental Anesthetic..... ◯ YES ◯ NO
- Sensitivity to Epinephrine (vasoconstrictor)... ◯ YES ◯ NO
- Antibiotics (Penicillin or Other)..... ◯ YES ◯ NO
- Latex (Allergy or Sensitivity)..... ◯ YES ◯ NO

Other: _____

HIV or AIDS..... ◯ YES ◯ NO

Hepatitis A, B or C..... ◯ YES ◯ NO

Drug or Alcohol Abuse Issues..... ◯ YES ◯ NO

Smoke or Chew Tobacco..... ◯ YES ◯ NO

Diabetes..... ◯ YES ◯ NO

Any Physical Limitations..... ◯ YES ◯ NO

Psychiatric Treatment ..... ◯ YES ◯ NO

Depression or Anxiety Disorder..... ◯ YES ◯ NO

Women: Are you pregnant?..... ◯ YES ◯ NO

Do you require "Premedication" with an antibiotic prior to dental treatment?..... ◯ YES ◯ NO

Any Medications or other Health Issues we should know about?:

Reviewed By and Notes: Date and Sign

Name: _____ Signature: _____

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Dental History

Patient's Name: _____ Date: _____

How would you describe your dental health? ◯ Good ◯ Fair ◯ Poor

What specific dental concerns do you have now? _____

How long ago was your last dental visit?
And what was the treatment? _____

Please mark any questions that you would answer 'YES".

- ☐ Are you here today because of an emergency/pain?
- ☐ Are you interested in "Comprehensive" care?
- ☐ Are you apprehensive about dental care?
- ☐ Have you had problems with previous dental treatment?

- ☐ Do you have sore, tender or bleeding gums?
- ☐ Have you had gingivitis or periodontal disease?
- ☐ Do you have your teeth cleaned more than twice a year?
- ☐ Have you seen a periodontal specialist for treatment?

- ☐ Are your teeth sensitive? And to what? (Check below)
  - ☐ Hot or cold foods/liquids?
  - ☐ Biting?
  - ☐ Other?

- ☐ Are you missing teeth other than wisdom teeth?
- ☐ Do you wear partials or dentures?
- ☐ Do you have any dental implants?
- ☐ Does food catch in your teeth? Any loose teeth?

- ☐ Have you had orthodontics (braces)?
  - ☐ Still wearing retainers?

- ☐ Do you clench or grind your teeth frequently?
- ☐ Do you wear a nightguard/ biteguard?
- ☐ Do you wear a sports guard when playing sports?

- ☐ Have you been diagnosed with a Tempormandibular (jaw) Disorder (TMJ or TMD)?
- ☐ Do you have headaches or jaw symptoms on wakening?
- ☐ Do you have pain in your face, jaw joint, neck or temples?
- ☐ Have you had any jaw or facial trauma?

- ☐ Is there anything you would change about your teeth?
  - ☐ Color?
  - ☐ Shape?
  - ☐ Spaces?
  - ☐ Alignment?
  - ☐ Other?

How often do you brush and floss? _____

What statement best describes the treatment you are seeking?

- ◯ Just want to avoid pain.
- ◯ Want to keep my teeth functional and healthy.
- ◯ Want to keep my teeth functional, healthy and good looking.

Anything else we should know? _____

Doctor's Notes:

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Office Policies

APPOINTMENT POLICY

We reserve the right to charge and collect $50.00 per scheduled hour for appointments that are missed or cancelled without 2 business days advance notice. Appointments are reserved exclusively for you. As a courtesy to you we may offer to move your appointment to an earlier time if openings arise.

In the event of an emergency after regular business hours a $150.00 emergency fee will be charged for patients in addition to the necessary treatment fees.

INSURANCE AND FINANCIAL POLICY

INITIAL

☐ Insurance is NOT a guarantee of payment; insurance companies will not pay for all your costs. Your policy is not a contract with our dental office, but between you and your insurer. NO INSURANCE PAYS FOR 100% OF ALL TREATMENT COSTS.

☐ Bannerwood Family and Cosmetic Dentistry does require payment in full for your estimated portion at time of service. We accept Visa, MasterCard, American Express, Cash and Checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with Care Credit, who offers 6 and 12 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on an approved credit

☐ *As a courtesy* we will be glad to file your insurance claims. We, at no time, guarantee what your insurance will or will not do with each claim. We also can not be responsible for any errors in filing your insurance. You as the patient are ultimately responsible for *all* treatment costs.

☐ If your account balance has not been paid in full within 90 days, either by you or your insurance company, the full balance for treatment rendered is your responsibility and considered due and collectible by law.

☐ If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. If we cannot obtain your insurance information, we can either see you as a private patient, with full payment due at time of service, or we can reschedule your appointment. If we need to reschedule your appointment, we reserve the right of the $50.00 cancellation charge.

☐ MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

☐ YOUR PATIENT PORTION IS AN ESTIMATE ONLY. YOU ARE STILL RESPONSIBLE FOR ALL TREATMENT COSTS EVEN IF THEY RUN HIGHER THAN THE ESTIMATION.

I have read and understand this financial policy. I agree to the requirements as stated.

Signature: _____ Date: _____

Patient Name: _____ Relation to Patient: _____

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Notice of Privacy Practices

PLEASE REVIEW CAREFULLY!

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 out dental care operations. Your personal health information will never be otherwise given to anyone - even family members - without your written consent. You, however, may authorize us in writing to disclose your information to a third party.

Our office 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 and employees, so you can be confident that your protected health information will never be improperly disclosed or released.

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

Collecting Protected Health Information
We will only request personal 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 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 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, email, 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 than 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 the office of Dr. Puneet Aulakh . Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

ACKNOWLEDGEMENT OF RECEIPTOF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Dr. Puneet Aulakh . The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of the office with respect to my protected health information.

Dr. Puneet Aulakh reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Signature: _____ Date: _____

DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

- ☐ Spouse
- ☐ Any of my immediate family
- ☐ Other (please specify): _____

Signature: _____ Date: _____

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Handle me with Care!!

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Please check next to the statements of concern. Feel free to comment in the space next to the question.

Patient care

- ☐ I gag easily
- ☐ I feel out of control when I'm lying down in the dental chair.
- ☐ Pain relief is a top priority for me.
- ☐ I don't like shots (or I've had a bad reaction to shots).
- ☐ I don't like cotton in my mouth.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise. It's like someone is scratching fingernails on a blackboard.
- ☐ I hate the noise of the drill
- ☐ I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and my dental hygiene.

Informed decisions

- ☐ I want to know the cost up front. No money surprises please.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ Please tell me what I need to know about my mouth in order to make an informed decision.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair. I might need you to make sure that I understand what is going on. Multiple times if necessary.
- ☐ I have health problems and questions that we need to discuss.

Other Concerns?

The Handle me with care Partenership pact.

I ask that you honestly inform me of all my dental concerns. I want you to make me aware of all my treatment options available. Then we can discuss how I can make healthy choices that will work within my budget. I also want to know all the pain and anxiety relief options available to me in your dental office, how each dental procedure will work, and how much of my time will be required.

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