Bellevue Specialized Dental Care

Welcome to our office. Please complete the following forms. The information provided on these forms is important to your care.

Patient's Name | Today's Date

Sex ☐ Male ☐ Female | Age | Date of Birth | SSN | e-mail Address

Address | City | State | Zip Code

Billing Address (if different) | City | State | Zip Code

Home Phone | Work Phone | Mobile

Spouse's Name and Phone # | Emergency Phone # (other than spouse)

Primary Dental Insurance | Group # | Subscriber's Name | ID# | DOB | SSN

Secondary Dental Insurance | Group # | Subscriber's Name | ID# | DOB | SSN

Primary Medical Insurance | Group # | Subscriber's Name | ID# | DOB | SSN

Secondary Medical Insurance | Group # | Subscriber's Name | ID# | DOB | SSN

Name & Phone of your Medical Doctor | Date of last visit | Name & Phone of your Dentist | Date of last visit

Referred to us by | Are you currently employed? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced | Current living situation ☐ Living alone ☐ Single parent ☐ Living with other adult(s) and children ☐ Living with other adult(s) with no children

1. Chief complaints (why are you here?)

2. Detection of problem

☐ I detected the problem ☐ My dentist found the problem ☐ My physician found the problem ☐ My fried/family found the problem

3. Do you clench or grind your teeth?

☐ Day ☐ Night ☐ Day & night ☐ N/A

4. Location of Oral Lessions (if applicable)

5. Location of Pain

A. Please MARK the locations of your pain: (R for right and/or L for left)

R	L		R	L		R	L		R	L		R	L	
☐	☐	Scalp	☐	☐	Forehead	☐	☐	Gum Tissue	☐	☐	Ear	☐	☐	Chest
☐	☐	Neck	☐	☐	Temple	☐	☐	Tongue	☐	☐	Eye	☐	☐	Lips
☐	☐	Shoulder	☐	☐	Upper jaw	☐	☐	Throat	☐	☐	Cheek	☐	☐	Extraction Site
☐	☐	Arm	☐	☐	Lower jaw	☐	☐	Roof of Mouth	☐	☐	Sinus			
☐	☐	Back	☐	☐	TMJ	☐	☐	Tooth	☐	☐	Denture Ridge			

B. How long have you had this pain? _____

C. Do you feel it is associated with your overall problem ☐ YES ☐ NO

D. When did it start in relation to your overall problem? ☐ Before ☐ During ☐ After ☐ Not applicable

6. When is the problem worse?

☐ At night	☐ When eating	☐ During day	☐ With use of medication	☐ At work
☐ Upon awakening	☐ With specific foods	☐ During stress	☐ Related to denture wearing	

Other: _____

7. Do you use any of the following to alleviate symptoms?

☐ Chewing gum	☐ Frequent sips of water or liquid	☐ Saliva substitute (Name:_____)
☐ Candies or mints	☐ Get up at night to drink water	☐ Mouthwash (Name:_____)
☐ Hot/cold packs	☐ Pain medications	

Other: _____

8. Do you have any of the following problems?

☐ Difficulty chewing dry food	☐ Pain with swallowing	☐ Need water or liquid to help swallow
☐ Pain with swallowing	☐ Reflux problems	

9. What does your pain feel like?

Some of the words below describe your PRESENT pain. Mark ONLY those words that best describe it. Leave out any category that is not suitable. Use only a single word in each appropriate category -the one that applies best-. If you are not feeling any pain at the moment, please leave box empty.

1 ☐ Flickering	4 ☐ Sharp	☐ Scalding	☐ Rasping	☐ Killing	☐ Numb
☐ Quivering	☐ Cutting	☐ Searing	☐ Splitting	15 ☐ Wretched	☐ Drawing
☐ Pulsing	☐ Lacerating	8 ☐ Tingling	11 ☐ Tiring	☐ Blinding	☐ Squeezing
☐ Throbbing	5 ☐ Pinching	☐ Itchy	☐ Exhausting	16 ☐ Annoying	☐ Tearing
☐ Beating	☐ Pressing	☐ Smarting	12 ☐ Sickening	☐ Troublesome	19 ☐ Cool
☐ Pounding	☐ Gnawing	☐ Stinging	☐ Suffocating	☐ Miserable	☐ Cold
2 ☐ Jumping	☐ Cramping	9 ☐ Dull	13 ☐ Fearful	☐ Intense	☐ Freezing
☐ Flashing	☐ Crushing	☐ Sore	☐ Frightful	☐ Unbearable	20 ☐ Nagging
☐ Shooting	6 ☐ Tugging	☐ Hurting	☐ Terrifying	17 ☐ Spreading	☐ Nauseating
3 ☐ Pricking	☐ Pulling	☐ Aching	14 ☐ Punishing	☐ Radiating	☐ Agonizing
☐ Boring	☐ Wrenching	☐ Heavy	☐ Gruelling	☐ Penetrating	☐ Dreadful
☐ Drilling	7 ☐ Hot	10 ☐ Tender	☐ Cruel	☐ Piercing	☐ Torturing
☐ Stabbing	☐ Burning	☐ Taut	☐ Vicious	18 ☐ Tight	

10. Pain instensity now

0 Not Intense ⟷ 10 Extremely Intense

11. How has your pain changed since the onset?

☐ Much improved ☐ Slightly improved ☐ Slightly worse ☐ Much worse ☐ Was better, now worse
☐ Improved ☐ Unchanged ☐ Worse ☐ Was worse, now better

12. What is the recurrence pattern of your pain?

☐ This is the first episode ☐ Recurs daily ☐ Constant ☐ Several recurrences a year
☐ Recurs several times daily ☐ Recurs weekly ☐ Recurs monthly ☐ Recurs less than yearly

13. Diagnostic tests and procedures

List in order all diagnostic tests and X-Rays, where they were conducted and results if you know them.

Test #1 _____ Location/Doctor _____ Finding _____
Test #2 _____ Location/Doctor _____ Finding _____
Test #3 _____ Location/Doctor _____ Finding _____

14. Treatments

List in order all of the treatments you have received and CIRCLE the number indicating how successful the treatment was. Include medications and physical therapy. NOTE: If no treatments, skip to next question.

	NO SUCCESS	SOME SUCCESS	GOOD SUCCESS	COMPLETE SUCCESS
Treatment 1 _____	0	1	2	3
Treatment 2 _____	0	1	2	3
Treatment 3 _____	0	1	2	3

15. Females only. Regarding your reproductive system, which of the following apply?

☐ Regular periods ☐ Going through menopause ☐ Vaginal itching ☐ Hormone therapy
☐ Irregular periods ☐ Presently pregnant (Month:____) ☐ Vaginal dryness ☐ Hysterectomy (At age:___)
☐ Menstrual pains ☐ Receive Depo-Provera injections ☐ Recurrent vaginal yeast infections
☐ Post menopausal ☐ Had ovary(ies) removed (At age:___) ☐ Vaginal ulcersUse birth control pills

Comments:_____

16. What other symptoms do you have?

☐ Hearing loss ☐ Urinary frequency ☐ Eye Dryness ☐ Itching or burning ☐ Enlarged tonsils
☐ Motion sickness ☐ Tend to feel hot ☐ Trembling ☐ Reflux ☐ Chronic sinusitis
☐ Dizziness ☐ Tend to feel cold ☐ Numbness ☐ Heartburn ☐ Mouth breathing
☐ Ringing ears ☐ Frequent headaches ☐ Paralysis ☐ Stomach pains ☐ Nasal obstruction
☐ Plugged ears ☐ Sleep difficulties ☐ Faint Easily ☐ Nausea ☐ Aching joints
☐ Earaches ☐ Coughing spells ☐ Convulsions ☐ Constipation ☐ Aching muscles
☐ Neck pains ☐ Cough up phlegm ☐ Sadness ☐ Diarrhea ☐ Back or shoulder pains
☐ Neck lumps ☐ Cough up blood ☐ Frustration ☐ Handwriting change ☐ Muscle cramping
☐ Neck swelling ☐ Wheezing ☐ Anxiety ☐ Excessively dry skin ☐ Arm/hand weakness
☐ Weight loss ☐ Night sweats ☐ Worry ☐ Congested nose ☐ Chest pain
☐ Weight gain ☐ Frequent colds ☐ Bleed easily ☐ Runny nose ☐ Shortness of breath
☐ Loss of appetite ☐ Blurry vision ☐ Bruise easily ☐ Head colds ☐ Racing heart
☐ Always hungry ☐ Double vision ☐ Skin rashes ☐ Nose bleeds ☐ Fluid retention
☐ Always thirsty ☐ Eye pain or itching ☐ Hay fever ☐ Sore throat ☐ Heart murmur
☐ Fatigue ☐ Watery eyes ☐ Indigestion ☐ Hoarseness ☐ Sleep difficulties
☐ Problems at work ☐ Sexual difficulties ☐ Reduced social activities

Comments:_____

17. Your medical history, Past & Present Illnesses:

☐ Cancer	☐ Arteriosclerosis	☐ Scoliosis	☐ Bronchitis	☐ Blood transfusion
Type: _____	☐ High Cholesterol	☐ Back problems	☐ Sinusitis	☐ Coagulation disorder
☐ Genetic Disease	☐ Other heart disease	☐ Arthritis	☐ Asthma	☐ Anemia
Type:_____	☐ Multiple sclerosis	☐ Chicken pox	☐ Tuberculosis	☐ Tobacco use
☐ Rheumatoid arthritis	☐ Epilepsy	☐ Herpes Zoster	☐ Kidney disease	☐ Anxiety
☐ Lupus	☐ Neuralgia	☐ Dermatitis	☐ Bladder disease	☐ Depression
Erythematosis	☐ Bells Palsy	☐ Encephalitis	☐ Hepatitis	☐ Suicide attempt
☐ Other autoimmune	☐ Stroke	☐ Meningitis	☐ Jaundice	☐ Eating disorder
disease: _____	☐ Migraine	☐ Apendicitis	☐ Strep throat	☐ Sleep difficulties
☐ Diabetes	☐ Hearing loss	☐ Gastric ulcer	☐ Mononucleosis	☐ Drug abuse
☐ Gout	☐ Visual Loss	☐ Colitis	☐ Rheumatic fever	☐ Alcohol abuse
☐ Obesity	☐ Glaucoma	☐ Pancreatitis	☐ Measles	☐ Recreational drug use
☐ Thyroid problems	☐ Cataracts	☐ Gastritis	☐ Mumps	☐ Venereal disease
☐ Poor nutrition	☐ Fractures	☐ Headaches	☐ German measles	
☐ Angina	☐ Concussion	☐ Enphysema	☐ Scarlet fever	
☐ Hypertension	☐ Osteoporosis	☐ Pneumonia	☐ Polio	

Comments:_____

18. Family medical history

Please Mark medical problems that have been present in your parents, brothers/sisters, children.

☐ Cancer	☐ Arthritis	☐ Seizures	☐ TMJ problems	☐ Gout
Type:_____	☐ Back Pain	☐ Hypertension	☐ Bruxism	☐ Diabetes
☐ Stomach or intestinal	☐ Drug abuse	☐ High Cholesterol	☐ Genetic disease	☐ Thyroid problems
problems	☐ Alcoholism	☐ Heart disease	☐ Rheumatoid arthritis	☐ Anemia
☐ Ulcers	☐ Glaucoma	☐ Malocclusion	☐ Lupus Erythematosis	☐ Blood coagulation
☐ Kidney disease	☐ Headaches	☐ Jaw Pain	☐ Other immune	☐ Sleep difficulties
☐ Bladder problems	☐ Migraine	☐ Jaw locking	system disease	☐ Anxiety
☐ Nervous breakdown	☐ Suicide	☐ Depression		

19. Have you experienced an allergic or unusual reaction to any of the following drugs?

☐ Penicillin	☐ Sulfa	☐ Aspirin	☐ Iodine
☐ Other antibiotic	☐ Local anesthesia	☐ Opiates/codeine	☐ Other drugs:_____

List other allergies (food, metals, etc.)

_____

20. Major hospitalizations

REASON	DATE

21. Current presciption medications and/or OTC

List all medications now or recently used and amount.

1 _____	4 _____
2 _____	5 _____
3 _____	6 _____

22. Dental history

☐ Regular dental care	☐ Treatment for jaw trauma/fracture	☐ Periodontal surgery	☐ Dentures
☐ Occasional dental care	☐ Emergency treatment only	☐ Other Oral surgery	☐ Orthodontics
☐ Tooth infection/abscess	☐ Wisdom tooth extractions	☐ Bite adjustment	
☐ Endodontic treatment	☐ Orthographic Surgery	☐ Night guard	

23. What kind of work have you done most of your life?

Patient Name: _____ David Aronowitz, D.D.S., M.S.D. 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. At BSDC Dr. David Aronowitz performs General Dentistry, Orofacial Pain/TMD and Oral Medicine and IV Sedation. I fully understand that I must inform about my medical condition, including medications and allergies (Latex, Specific medications, Sodium Bisulfite, certain foods) during the exam, and inform if any changes happened during my dental treatment.. I fully understand that any omission of this information could represent a risk during and after my dental treatment. 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 or to be re-scheduled.

4. If medical conditions are present I allow Dr. Aronowitz and associates 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, if the situation is not life threatening I was advise to call the office.

7. Local anesthetics will 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, postanesthetic intraoral lesion, etc. If I don't 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. The Dr. could deny treatment is designated driver is not present.

9. Vital signs are taken prior to any dental procedure involving local anesthetics and other drugs. If anything is abnormal the Doctor will discuss it with me, my appointment might be reschedule and a possible medical consultation might be needed.

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 minutes to 10 hours.

11. When an infection is present local anesthetics might not be 100% effective. Treatment might need to be re-scheduled, and antibiotics and 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 (surgical extractions, periodontal surgery, and complicated root canal treatments).

14. After selective procedures I will be provided with an emergency cellular phone number. I agree to use it ONLY for emergencies related to that procedure. I should not use it for general questions, cancellations, financial statements, etc.

15. Questions concerning financial plans, insurance coverage, benefits, WILL NOT BE ANSWERED BY DR. ARONOWITZ. They will be answered by the office manager or other staff members.

16. As a matter of office policy, at least 1staff members 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.

_____ _____

Patient /guardian signature Date

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

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.