PATIENT REGISTRATION and AUTHORIZATION for ADULTS Date: / /

ABOUT YOU

Name: Preferred Name:

Gender: M F Status: Single Married Child Other Birthdate: / / AGE:

Social Security Number: Email:

Home Address:

City: State: Zipcode:

Home Phone Number: Mobile Phone Number:

Employer: Employer Phone Number:

Emergency Contact and Phone Numbers: (not living at same address)

ABOUT YOUR SPOUSE

Name: Preferred Name:

Gender: M F Birthdate: / / AGE: Social Security Number:

Mobile Phone Number: Email:

Employer: Employer Phone Number:

Is your spouse a patient of record? YES NO May we contact them to help schedule their first visit with us? YES NO

AUTHORIZATIONS

Permission is granted to Dentistry of Bellevue, all Associates and Staff to have full rights to disclose my personal and private information to the following listed people: (Name and relationship)

I am aware this gives this/these person/people full access to my dental/medical records. Any limitations are noted here:

This includes treatment recommendations, treatment completed, medications, health history, discussion of finances, chart notes and any other information my dental team deems necessary for my proper care. A spouse or significant other is NOT automatically authorized.

I can revoke this authorization by writing at any time.

ABOUT YOUR COVERAGE

Primary Insurance Company: Group Number:

Subscriber Name: Date of Birth: / /

Identification Number: Social Security Number:

Secondary Insurance Company: Group Number:

Subscriber Name: Date of Birth: / /

Identification Number: Social Security Number:

When was your last dental visit: What brings you in today?:

How did you hear about us?

 Signature of Patient or Guardian

PATIENT REGISTRATION and AUTHORIZATION for ADULTS Date: / /

HEALTH HISTORY

Are you under the care of a Physician: NO YES Reason:

Name and Phone Number of Doctor:

Have you been hospitalized in the past 12 months: NO YES Explain:

Do you smoke or use tobacco in any form: NO YES How much/how often?

Please list any prescription, over the counter drugs or herbal supplements you are currently taking/using:

Have you have or ever had the following (please circle multiple choice):

Y	N	COVID-19	Y	N	Diabetes	Y	N	Nervous Disorder, Epilepsy/Seizures
Y	N	Abnormal Bleeding	Y	N	Heart Attach/Stroke	Y	N	Pacemaker/Defibrillator
Y	N	Aids/HIV	Y	N	Heart Disease/Heart Failure	Y	N	Radiation Treatment
Y	N	Arthritis/Rheumatism	Y	N	Heart Murmur, Angina	Y	N	Rheumatic/Scarlet Fever
Y	N	Artificial Bones/Joints/Heart Valves	Y	N	Hepatitis A B C	Y	N	Shingles
Y	N	Asthma	Y	N	High or Low Blood Pressure	Y	N	Sinus Problems
Y	N	Autoimmune disease	Y	N	Liver Disease	Y	N	Thyroid Problems
Y	N	Cancer/Chemotherapy						

HAVE YOU EVER BEEN TOLD YOU NEED ANTIBIOTICS BEFORE DENTAL CARE? YES NO

ARE YOU CURRENTLY TAKING BLOOD THINNERS? YES NO

Have you had and ALLERGY or ADVERSE REACTION to any of the following:

YES	NO	**Aspirin, Acetaminophen, Ibuprofen**	YES	NO	**Latex**	YES	NO	**Penicillin or other Antibiotics**
YES	NO	**Barbiturates, Sedatives**	YES	NO	**Local Anesthetics**	YES	NO	**Sulfa Drugs**
YES	NO	**Codeine, Demerol, or other Narcotics**	YES	NO	**Metal/Plastic**	YES	NO	**Other**

Have you ever had any problems with dental treatment performed? Please explain: (example: hard to numb, lots of bleeding with teeth removal, did not stay numb long)

Women only: ARE you pregnant? YES DUE DATE: NO: Nursing YES NO

ANYTHING ELSE WE SHOULD BE AWARE OF?

At Dentistry of Bellevue we strive to maintain being a high-quality and personalized dental practice that is committed to excellence and affordability. Our goal when treating you is to keep you involved as an active participant in your dental care. In order for us to provide quality, efficiency, and affordable services we request you pay your estimated costs at the time of service. This will reduce billing issues, fee collecting costs, and fees charged to you.

 Signature of Patient or Guardian

I, the undersigned, do hereby acknowledge that I have read, answered to the best of my knowledge, and understood all statements on this document:

- We keep a record of the dental/health care services we provide you. You may ask to see and receive a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.
- I acknowledge availability of a copy of the office Notice of Privacy Practices should I wish to receive one.
- My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996.
- I understand that this information will be held in the strictest of confidence and if I ever have any changes in my health or medicines, it is my responsibility to inform the office and doctor at my next appointment.
- This office offers Nitrous Oxide (Laughing gas) to our patients for a fee. Most insurance does NOT pay for this option and payment is due at time of use.
- This office accepts most insurances but this does **NOT** guarantee payment of coverage from insurance companies. Payment is due at or before time of service. To this end, I authorize the release of any medical/dental information requested by my insurance company. I authorize payment of benefits directly to Dentistry of Bellevue.
- Finance charges may be charged to balances over 60 days at the rate of 9% per annum. If my account becomes past due, I/we agree to pay all attorney fees, court costs, filing fees and process service fees which may be assessed by any collection agency or law firm retained to pursue the matter and for the venue and jurisdiction to be in King County.
- You and /or your assignees are hereby authorized to contact me by any telephone numbers, pagers, cell phones, emails and addresses provided by me, or otherwise obtained by you, using an automatic telephone dialing system and to leave prerecorded messages on these devices.
- I hereby authorize my Providers office to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper medical/dental care including but not limited to x-rays, CT scans, photographs, anesthetic, ect.
- Payment is due at or before the time services are rendered.
- We realize your time is valuable and your schedule may change so it may be necessary to reschedule or cancel your appointment. Your appointment time is reserved just for you. We reserve the right to charge a minimum of $75 per hour appointment in order to cover expenses occurred during the allotted time for your appointment should you not show up or your appointment is cancelled with less than 48 hours' notice.

_____ _____

Signature of Patient or Guardian Date

Print Name:_____.