PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST FIRST MI	DATE OF BIRTH	SEX	SSN(US) / SIN(CAN)

PREFER TO BE CALLED	HOME PHONE #	CELL PHONE #

PATIENT'S ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE	E-MAIL

MARITAL STATUS ☐S ☐M ☐W ☐D ☐ UNDER AGE 18	PATIENT'S / GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE	WORK PHONE #

SPOUSE'S NAME LAST FIRST MI	SPOUSE'S EMPLOYER	OCCUPATION

SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE	WORK PHONE #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP

HOME PHONE #	WORK PHONE #	CELL PHONE #

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO
Contact me at home	☐	☐
Contact me via cell phone	☐	☐
Contact me at work	☐	☐
Contact me via e-mail	☐	☐
Leave messages on my home voicemail	☐	☐
Leave messages on my cell phone voicemail	☐	☐
Leave messages on my work voicemail	☐	☐

PLEASE PRINT

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CAN)
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

SECONDARY COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CA)
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO
Health Care Providers	☐	☐
Insurance Companies	☐	☐

OTHERS (PLEASE PRINT)

1.

2.

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL

☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE

If the above named Patient is a minor or unable to pay the his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies.

SIGNATURE - GUARANTOR OF PATIENT	DATE

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
○ aspirin, ibuprofen, acetaminophen, codeine _____		
○ penicillin _____		
○ erythromycin _____		
○ tetracycline _____		
○ sulfa _____		
○ local anesthetic _____		
○ fluoride _____		
○ chlorhexidine (CHX) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) __	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)** 

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Bellevue Dentist

FINANCIAL POLICY

Thank you for choosing our dental office. We are committed to providing the best dental care possible. Please understand that payment of your bill is considered part of your treatment. The following statement explains our Financial Policy. Please read carefully.

- Please provide accurate, complete personal, and insurance information prior to treatment.
- All applicable co-pays, account balances, both current and prior, are due at the time of service.
- We accept cash, check, all major credit cards, and HSA cards.

Dental Insurance

Our office participates as a Premier Provider with Delta Dental. While our office is able to bill most insurance plans, ***our rates are only contracted with Delta Dental***. If you have a plan that is not affiliated with Delta Dental, please contact your insurance company to ensure that you are able to see an out-of-network dentist. Please be aware that it is the patient's responsibility to understand their dental benefits, and that insurance is a contract between the patient, and their insurance company. In addition, insurance estimates are not a guarantee of coverage as the final determination of payment is determined by the insurance provider at the time a claim is received. If you are uncertain about the limitations of your policy, please contact your insurance provider to learn more about your benefits, and potential out-of-pocket expenses. If you have any concerns, please do not hesitate to let us know. We are happy to help.

Cost of Treatment

Treatment plans are customized to the patient's individual care. To that end, we do our best to make patients aware of their financial investment, and do so by providing ***estimates*** of out-of-pocket expenses based on the patient's insurance coverage. Please know that any estimate given is just an estimation of costs, as insurance providers do not guarantee coverage until a claim is received.

Financing

Our office does not offer "in-house" financing; however, we can help you work with CareCredit if financing is needed. We accept cash, check, all major credit cards, and HSA cards.

Missed Appointments

Our office requires two business days notice in order to cancel, or reschedule, an appointment. Patients that cancel appointments with less than two business days notice will be assessed a $60 fee.

I authorize Dr. Siamak Najafi to release pertinent dental/medical information to my insurance company when requested, or in order to facilitate payment of a claim. I authorize my insurance benefits to be paid directly to Dr. Siamak Najafi.

Financial Guarantor - Printed Name _____ Signature_____

Date_____/_____/_____

PHONE 425-644-2205 | EMAIL info@bellevuedentist.com | ADDRESS 14645 Bel-Red Road Suite 100, Bellevue WA 98007

STATEMENT OF PRIVACY PRACTICES OVERVIEW

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receives appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and 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 WA. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. 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, integrity, and access to 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 (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health 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 or fund-raising 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 unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

YOUR RIGHTS AS OUR PATIENT

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.

IF you'd like a full and complete copy of our Statement of Privacy Practices, please ask at the front desk.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Bellevue Dentist. 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 this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Bellevue Dentist reserves the right to change the privacy practices currently 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 or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA.)

Spouse only	☐ **YES**	☐ **NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	☐ **YES**	☐ **NO**
OTHER: (Name) **Telephone #:**	☐ **YES**	☐ **NO**

Name of patient (please print):

Patient signature (if 18+ years of age):

Patient's personal representative: (Please Print):

Personal Representative's signature:

Representative's Telephone Number: **Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:**
Reason for not obtaining patient signature:	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	

Bellevue Dentist

RELEASE OF RECORDS

Patient Name: _____
Date of Birth: _____

I authorize the staff of _____ to release, and transfer, my dental care information (all x-rays, hygiene visits and periodontal charting and any pending treatment) to the name below:

Bellevue Dentist
14645 Bel-Red Rd, Suite 100
Bellevue, WA 98007

_____
(Signature of the Patient, or patient's representative)

_____
(Date Signed)