Bannerwood Cosmetic and General Dentistry
Puneet Aulakh DDS

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: ______________________ Date of Birth: ______________________

Address: ______________________ SSN: ______________________

City, State, Zip: ______________________ E-mail: ______________________

Home Phone: ______________________ Emergency Contact: ______________________

Work Phone: ______________________ Emergency contact phone: ______________________

Cell Phone: ______________________ Referred by: ______________________

PERSON RESPONSIBLE FOR ACCOUNT

Name: ______________________ Home Phone: ______________________

Address: ______________________ Relation to Patient: ______________________

City, State, Zip: ______________________ E-mail: ______________________

DENTAL HISTORY

	YES	NO
Are you apprehensive about dental treatment?	[ ]	[ ]
Have you had problems with past dental treatment?	[ ]	[ ]
Do you gag easily?	[ ]	[ ]
Do you wear dentures?	[ ]	[ ]
Does food catch between your teeth?	[ ]	[ ]
Do you chew on only one side of your mouth?	[ ]	[ ]
Do you avoid brushing any part of your mouth because of pain?	[ ]	[ ]
Do your gums bleed easily?	[ ]	[ ]
Do your gums bleed when you floss?	[ ]	[ ]
Do your gums feel swollen or tender?	[ ]	[ ]
Have you ever noticed slow healing sores in or About your mouth?	[ ]	[ ]
Are your teeth sensitive?	[ ]	[ ]
Do you feel twinges of pain when you teeth come in contact with:		
Hot foods or liquids?	[ ]	[ ]
Cold foods or liquids?	[ ]	[ ]
Sours?	[ ]	[ ]
Sweets?	[ ]	[ ]
Do you take fluoride supplements?	[ ]	[ ]
Are you dissatisfied with the appearance of your teeth	[ ]	[ ]
Do you prefer to save your teeth?	[ ]	[ ]
Do you want complete dental care?	[ ]	[ ]

	YES	NO
How often do you brush? ______________________		
How often do you floss? ______________________		
Does your jaw make noise so that it bothers you or others?	[ ]	[ ]
Do you clench or grind your jaws frequently	[ ]	[ ]
Does your jaw get stuck so you can't open freely?	[ ]	[ ]
Does it hurt when you chew or open to take a bit?	[ ]	[ ]
Do you have earaches or pain in front of the ears?	[ ]	[ ]
Do you have any jaw symptoms or headaches upon waking in the morning?	[ ]	[ ]
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	[ ]	[ ]
Do you find jaw pain or discomfort extremely frustrating or depressing?	[ ]	[ ]
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants)?	[ ]	[ ]
Do you have a teporomandibular (jaw) disorder (TMJ)	[ ]	[ ]
Do you have pain in the face, cheeks, jaws, joints throat, or temples?	[ ]	[ ]
Are you unable to open your mouth as far as you want?	[ ]	[ ]
Are you aware of an uncomfortable bite?	[ ]	[ ]
Have you had trauma to the jaw?	[ ]	[ ]
Are you a habitual gum chewer or pipe smoker?	[ ]	[ ]

MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer/Tumor	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other ______		

Notes: ______________________

____

______________ Date: ________

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? ______		
Do you smoke?	☐	☐
If so, how much? ______		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?
If so, please describe: ______________________

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Other ______		

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: ______		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms? ______		

Notes: ______________________

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Patient/Parent Signature: ______________________

Dentist Initial: ______________________

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OFFICE FINANCIAL POLICY

Payment is due at the time services are rendered. For your convenience we accept cash, Visa, MasterCard, Discover, or personal check.

Insurance benefits are determined by your employer and not your dentist. **Any deductible or estimated co-payment amount will be due at the time of treatment**. Insurance is not a guarantee of payment; insurance companies will not pay for all your costs. Your insurance policy is a contract between you and your insurer. Your insurance and payment are still your responsibility. As a courtesy we will be glad to file your claim for you if you bring 1) your dental insurance wallet card and 2) all required employer information. You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment. **If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.**

We reserve the right to charge and collect $50.00 for appointments that are broken or cancelled without 48-hours 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.

Returned Check Fee of $40 will be added to your account balance and is collectible.

Payment plans and financial arrangements can be offered for comprehensive dental treatment prior to commencing treatment.

I have read and understand this financial policy.

______________________	______________________
Name of Patient or Personal Representative	**Signature of Patient** or Personal Representative
______________________	______________________
Date	Description of Personal Representative's Authority

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STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protecting 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 of 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 out 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 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.

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 you 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 Bannerwood Dental. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Bannerwood Dental. 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.

ADDITIONAL DISCLOSURE AUTHORITY

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:

ANY OF MY IMMEDIATE FAMILY	[ ] YES	[ ] NO
SPOUSE ONLY	[ ] YES	[ ] NO
OTHER (PLEASE SPECITY) ______________________	[ ] YES	[ ] NO

______________________ ______________________

Name of Patient or Personal Representative — **Signature of Patient** or Personal Representative

______________________ ______________________

Date — Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

Provided Prior to Treatment: [ ] YES [ ] NO
Date Provided: ______________________

RESON FOR DENIAL:
[ ] Needed more time to review statement of Privacy Practices
[ ] Wanted to consult with another person before signing
[ ] Unable to sign
[ ] Reason not given
[ ] Other (explain) ______________________