Bellevue Tulip Dental | 11216 NE 15th St Suite B, Bellevue, WA 98004 | (425) 451-8611

PATIENT REGISTRATION

PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Preferred Name:

Birth date: (MM/DD/YY)	Age:	Sex: ☐ Male ☐ Female	Soc. Sec:	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Address:	City:	State:	Zip:

Home Phone:	Cellular: Text: ☐ Yes ☐ No	Work Phone:

Email: ☐ I would like to receive correspondences via email.

Referred by:

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

First Name:	Last Name:	Middle Initial:	Preferred Name:

Birth date:	Age:	Sex: ☐ Male ☐ Female	Soc. Sec:

Address:	City:	State:	Zip:

Home Phone:	Cellular: Text: ☐ Yes ☐ No	Work Phone:

Email: ☐ I would like to receive correspondences via email.

PRIMARY INSURANCE INFORMATION

Subscriber's First Name:	Subscriber's Last Name:	Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Birth date: (MM/DD/YY)	Subscriber's Soc. Sec:	Employer:
Ins. Company:	ID:	Group Number:

SECONDARY INSURANCE INFORMATION

Subscriber's First Name:	Subscriber's Last Name:	Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Birth date: (MM/DD/YY)	Subscriber's Soc. Sec:	Employer:
Ins. Company:	ID:	Group Number:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF BELLEVUE TULIP DENTAL PRIVACY PRACTICES

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPPA)**, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

✓ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

✓ Obtain payment from third-party payers.

✓ Conduct normal healthcare operations such as quality assessments and health care professional certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my health care information to the persons indicated below (please check all that apply): ☐ **Nobody** ☐ **Any Member of My Immediate Family** ☐ **Spouse only** ☐ **Other** _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

PLEASE READ AND INITIAL

_____I request and authorize Dr. Carolina Florencio to provide me and/or my children, with dental care.

_____I understand that Bellevue Tulip Dental requires 48-hour notice if there are to be changes made to a scheduled appointment. Any appointment change made with less than 48-hour notice will be assessed a fee of $50.00.

_____Assignment of Insurance: I authorize my insurance benefits be paid directly to Bellevue Tulip Dental. I know that I am ultimately responsible for any unpaid balance on my account, for myself and my children, regardless of my marital status. I understand balances over 90 days will be placed in collection status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

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MEDICAL AND DENTAL HEALTH HISTORY

Name: | Birth date: (MM/DD/YY)

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, describe:

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, describe:

Have you ever had a serious neck or head injury? ☐ Yes ☐ No If yes, describe:

Are you taking any medication or drugs? ☐ Yes ☐ No If yes, describe:

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Latex ☐ Local Anesthetics ☐ Other: _____

Woman: ☐ Pregnant ☐ Nursing ☐ Taking oral contraceptives

Check if you have history of any of the following:

☐ High Blood Pressure	☐ Heart or bypass surgery	☐ Hepatitis or Jaundice	☐ Epilepsy or Seizure
☐ Heart Murmur	☐ Smoke	☐ Anemia	☐ Stomach ulcer
☐ Rheumatic fever	☐ Stroke	☐ Bleeding disorder	☐ Intestinal problems
☐ Mitral valve prolapse	☐ High Cholesterol	☐ Kidney disease	☐ Arthritis
☐ Chest Pain	☐ Emphysema	☐ Renal Dialysis	☐ Artificial joints
☐ Heart Attack	☐ Asthma	☐ Organ transplant	☐ Sexually transmitted disease
☐ Artificial heart valve	☐ Diabetes	☐ Cancer	☐ HIV
☐ Irregular heart beat	☐ Thyroid disease	☐ Osteoporosis	☐ Tuberculosis (TB)
☐ Pacemaker	☐ Liver disease	☐ Radiation or Chemotherapy	☐ Psychiatric Treatment

Have you ever had any serious illnesses not listed above? ☐ Yes ☐ No If yes, describe:

DENTAL HISTORY

Reason for your first visit: ☐ Establishing Care/Check-up ☐ Emergency ☐ Cosmetic

Please describe any immediate concerns: Such as sensitivity to hot/cold/pressure, bleeding gums, interest in cosmetic procedures, etc.

Are you happy with your smile? ☐ Yes ☐ No Comments:

Have you received any of the following dental treatments in the past?

☐ Wisdom Tooth Extraction	☐ Scaling and root planning (Deep Cleaning)
☐ Nightguard	☐ Bone or gum grafting
☐ Orthodontic Treatment (Braces)	☐ Dentures
☐ Implants	☐ Facial or Jaw surgery

Do you have any dental anxiety? ☐ Yes ☐ No If yes, is there anything we can do to make you your visit more comfortable?

Are you happy with your previous dental care? ☐ Yes ☐ No If no, please let us know how we can improve your experience.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN | DATE

Release of Records

Bellevue Tulip Dental

Patient Name:_____

Patient Date of Birth:_____

To whom it may concern:

I hereby authorize any requested clinical information to be released electronically to:

Bellevue Tulip Dental
Dr. Carolina Florencio, DMD
11216 NE 15th St Ste B
Bellevue, WA 98004
Ph#425-451-8611
Email address: frontdesk@tulipdental.net

From the provider listed below:

Doctor Name:_____

Practice:_____

Address:_____

Ph#_____ Fx#_____

Email:_____

Please forward the following via email:

- CURRENT X-RAY IMAGING
- PERIO CHARTING
- PENDING TREATMENT

Thank you for your assistance.

_____ _____
(Patient Signature) (Date)