Holistic Dentistry

Daniel Mashoof D.M.D.
1418 112th Ave NE Suite 200 . Bellevue . WA . 98004
425-454-7801

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Email Address: _____

Address: _____
Street Apartment #

_____ *WA* _____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Date of last health care exam: _____What was this exam for?_____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:_____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	H.I.V. Infection/AIDS	No	Yes

Are you required to Pre-Medicate before dental treatment? No Yes

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
If yes, what is it usually: S /D

Are you allergic or have you had a reaction to:
a. Local anesthetics ..... No Yes
b. Penicillin or other antibiotics ..... No Yes
c. Aspirin ..... No Yes
d. Codeine, valium or other sedatives..... No Yes
e. Other _____

Are you a smoker? No Yes
If so, how much do you smoke per day? _____

Do you snore? No Yes Do you get frequent headaches? No Yes

Please list any medications you are currently taking:
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? _____

Do you take Antacids? No Yes If yes, how often? _____

Are you taking any herbal supplements/medicines? No Yes If yes, which ones?_____

Diet: Restricted Diet _____
How many meals a day _____
Food Allergies _____
Sugar in your diet: ❑ None ❑ Slight ❑ Moderate ❑ High

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Website
☐ Your Insurance Provider ☐ Internet ☐ Google ☐ Bing ☐ Yelp ☐ Other _____
Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:

_____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:

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Consent for Services

Payment for treatment rendered is expected at the time of treatment. Should you need a payment plan, the following options are available and again, expected at the time of treatment. We accept Visa/MC/Amex/Care Credit/Check or Cash. With a signed "Payment Agreement", a 3month payment plan may be offered for larger treatment cost with 25% of the copayment due at time of service and a Credit Card or Debit Card on file to auto charge each month. Please note: 1% interest applies to ALL balances over 60 days. Appointments and treatment are scheduled as you the patient have requested, however in some instances treatment plans may change and additional treatment may be needed in the best interest of your dental health. This may change the cost of your treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Interest in the amount of 1% will be charged on all account balances over 60 days.

In consideration for the professional services rendered to me, at my request, by Dr. Daniel Mashoof, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Holistic Dentistry

Daniel Mashoof D.M.D.

Here at Holistic Dentistry, Dr. Daniel Mashoof strives to provide the highest quality of dental care in a pleasant and supportive atmosphere.

To make our relationship more comfortable, we offer the following information on our financial policies, insurance billing, cancellations and failed appointment policy. To avoid any misunderstanding, please take a moment and read these policies before signing.

Financial Policy

Payment for treatment rendered is expected at the time of treatment. Should you need a payment plan, the following options are available and again, expected at the time of treatment. We accept Visa/MC/Amex/Care Credit/Check or Cash. With a signed "Payment Agreement", a 4-month payment plan may be offered for larger treatment cost with 25% (1st payment) of the copay due at time of service and a Credit Card or Debit Card on file to auto charge each month. Please note: a 1% interest applies to ALL balances over 60 days. Appointments and treatment are scheduled as you the patient have requested, however in some instances treatment plans may change and additional treatment may be needed in the best interest of your dental health. This may change the cost of your treatment. Initial _____

Insurance Billing

For our patients with insurance, as a courtesy we are happy to file all dental claims for your convenience; however, your help in being sure your insurance company pays the claim is required. Also please understand the guidelines and allowable dental maximums are set by your employer and are a contract between you, your employer, and your Insurance Company. We make every effort to assist you in these guidelines set forth by your insurance company; however, ultimately the fees charged for all services you received in this office are your responsibility. Any treatment rendered that is not covered by your insurance policy is due in full by you. In addition, understand that many Insurance companies have frequencies for most services, your insurance may also downgrade coverage percentages for white composite fillings and porcelain crowns, this information would be listed in your benefit booklet of which we are not privy to. Many Insurance companies do not see the value of your health thus; preventive treatments such as Val Scope (Oral Cancer Screenings), Fluoride, Sealants, additional Perio Maintenance Cleanings, Night Guards, and Sleep Appliances may not be covered by your plan. If not covered, please express to your employer that you deserve these benefits in the best interest of your health. Initial _____

Cancellations & Failed Appointments

Out of consideration to both your Doctor and our team, we kindly ask if you are unable to keep a reserved appointment time set for you, please call our office immediately. A 48 hour notification is required to avoid a $75 fee per hour of scheduled time. This fee will also be assessed to all failed and short notice cancelled appointments. Please know we make every effort, as a courtesy to remind you of your appointments, however you are ultimately responsible for your appointments made, and this includes advanced scheduled hygiene appointments out, 4-6 months. We would like to help you with a 20 day advance reminder of your appointments through your email. Please double check that we have the best e-mail and updated cell phone to reach you. Initial _____

Thank you for signing below in acknowledgement of these policies.
We look forward to providing you with optimal care for years to come.

Signature_____Date_____

Print Name _____

THE NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is still in effect. We reserve the right to change our privacy practices and terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information that we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our health care operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it is effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using your professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to all authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photo copies. We may charge you a reasonable, cost-based fee for responding to this request. We will use the format you request unless we cannot practicably do so.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14th, 2003. If you request this accounting more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide our agreement (except in an emergency).

Alternative Communication: You the right to request that we communicate with you about your health information by alternative means or to alternative location. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.
Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. If you want more information about our privacy practices or have any questions, please contact us.

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HIPAA Compliance Form

WASHINGTON REGION-Notice of Privacy Practice Acknowledgement

In accordance with Washington State law, we keep a record of the dental care service we provide you. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records or get information about your records by contacting the office manager.

This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

By signing below I acknowledge receipt of the Notice of Privacy Practices.

Signature:_____ ***Date:***_____

Relationship to patient (please check): _____*self* _____*legal guardian*

other: _____