Debra L. Cederbaum, D.D.S.

Welcome! Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Patient Information

Legal Name: _____ Preferred Name _____
First MI Last

Preferred Gender Pronouns (i.e. she/her, he/him) _____ Date: _____ DOB _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail _____ Circle One: Single Married Separated Divorced Widowed Partner

Home Phone #: _____ Work Phone #: _____ Cell #: _____

Do you prefer to receive calls at: __ Home __ Work __ Cell __ E-mail Sex: M / F

You or your parent's employer: _____ Occupation: _____

Spouse's or parent's name: _____ Work Phone #: _____

Person to contact in case of emergency: _____ Phone #: _____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Employer: _____ Work Phone #: _____

Insurance Information

Primary

Name of insured: _____

Relationship to patient: _____

Employer: _____

DOB: _____ ID#: _____

_____ _____
Insurance Company Program/Group #

_____ _____
Claims Address Phone #

Secondary

Name of insured: _____

Relationship to patient: _____

Employer: _____

DOB: _____ ID#: _____

_____ _____
Insurance Company Program/Group#

_____ _____
Claims Address Phone #

Referral Information

___ Dental Office ___ Yellow Pages ___ PPO List ___ Current Patient ___ Web Site ___ Other

Name of person or office referring you to our practice: _____

Permit for treatment and surgical care: I hereby grant permission to the staff of Debra L. Cederbaum, DDS to employ such established treatment therapy as may be deemed professionally necessary and advisable.
Financial Agreement: All charges for services will be paid upon completion of appointment. All outstanding balances shall accrue interest at the rate of 18% per annum. This is in addition to reasonable attorney fees, court cost, and collection agency expenses not to exceed 50% of the amount due at the time of assignment.
If insurance is involved: I hereby authorize payment directly to Debra L. Cederbaum, DDS of group benefits otherwise payable to me. I authorize credit inquires deemed necessary in connection with my account.
Cancellation Policy: There will be a $45 charge for all canceled or failed appointments without 48 hours notice.

Continue on Back

Dental Insurance and Financial Arrangements

Our office is committed to providing you with the best dental care. In order to achieve this goal, we need your cooperation as well as your understanding of this payment policy.

Payment for services is due at the time the care is provided, unless other arrangements are made with our Financial Coordinator. We accept cash, personal checks, Visa, MasterCard and Discover.

If you have dental insurance, we are available to help you receive your maximum allowed benefits. We will gladly process your insurance claim forms provided we are given complete and accurate insurance information, as well as release of benefits and information to your insurance company. We expect and appreciate payment of the "estimated" patient portion for your treatment at the time of the visit. Your insurance is a contract between you and your insurance company; therefore, all balances on account is your responsibility. Insurance companies that require their own forms must be provided by you.

Charges are made for broken or cancelled appointments without 48 hours notice (excluding weekends and holidays). We do not carry accounts over 90 days and if your pending insurance claims reach this point we will be asking for your assistance in dealing with your insurance company. We bill your dental insurance claims as a courtesy service only. Interest of 1-1/2% per month is charged to accounts over 90 days.

If you have any questions regarding our financial policy, please contact our office and we will be happy to answer them.

I hearby certify that I have read and agree to the policies described above.

_____

Signature Date

Debra L. Cederbaum, D.D.S.

Dental History

Name:_____ Age:_____ Date:_____

Former Dentist:_____

Reason for today's visit:_____

Date of last exam:_____ Date of last dental X-rays:_____

How often do you brush?_____ How often do you floss?_____

Please check any of the following that apply to you:

1.__ Bad breath	2.__ Dental Fear	3.__ Sensitivity to cold
4.__ Bleeding gums	5.__ Grinding Teeth	6.__ Sensitivity to hot
7.__ Broken teeth or fillings	8.__ Sore jaw muscles	9.__ Sensitivity to sweets
10.__ Loose teeth	11.__ Clicking or popping jaw	12.__ Sensitivity to bite
13.__ Periodontal treatment	14.__ Sores or growths in your mouth	15.__ Take fluoride supplements

__ Have experienced unfavorable dental treatment
__ Have experienced breathing laughing gas (nitrous oxide) with your dental treatment
__ *Would prefer* using laughing gas (nitrous oxide) with your dental treatment

__ Need to take antibiotic prophylaxis before dental treatment

__ Have experienced a reaction to penicillin, dental anesthetic or other
*Please specify and describe:*_____

Medical History

Physician:_____ Date of last visit:_____

List of current medications:_____ _____
_____ _____
_____ _____

Allergies:_____

Women: Are you pregnant? Y / N Nursing? Y / N Taking birth control pills? Y / N

Please check any of the following conditions you currently have or have had in the past:

1.__ AIDS	2.__ Diabetes	3.__ HIV Positive	4.__ Rheumatic Fever
5.__ Alcoholism	6.__ Epilepsy	7.__ Kidney Disease	8.__ Sinus Trouble
9.__ Anemia	10.__ Fainting	11.__ Liver Disease	12.__ Stroke
13.__ Arthritis	14.__ Glaucoma	15.__ Mitral Valve Prolapse	16.__ Thyroid Problems
17.__ Artificial Heart Valves	18.__ Heart Murmur	19.__Osteoporosis	20.__ Pacemaker
21.__ Artificial Joints	22.__ Heart Problems	23.__ Prolonged Bleeding	24.__ Tobacco Habit
25.__ Asthma	*describe*_____		26.__ Tonsillitis
27.__ Back Problems			
28.__ Blood Disease	29.__ Hemophilia	30.__ Psychiatric Care	31.__ Tumor
32.__ Cancer	33.__ Hepatitis	34.__ Radiation Treatment	35.__ Ulcer
36.__ Chemotherapy	37.__ High Blood Pressure	38.__ Respiratory Disease	

39.__ Other:_____

40._ Have you had filler _____

41._Have you had Botox _____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Dr. Debra L. Cederbaum, D.D.S.
5025 25th Ave. NE, Suite 205
Seattle, Wa. 98105
(206) 524-1314

16150 N.E. 85th St., Suite 212
Redmond, Wa. 98052
(425) 867-5119

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other