Aesthetic
Restorative&
Implant
DENTISTRY NORTHWEST

Welcome to the office of Dr. Ariel Raigrodski, DMD, MS, FACP

We wanted to extend to you our personal greetings and a very warm welcome to our dental practice. We are accepting new patients, and we are committed to doing everything possible to provide you with high quality, state-of-the-art dental care. We have prepared this packet of information and patient forms to make your visit to our office as pleasant and as comfortable as possible.

When you come for your initial appointment, please bring the following with you:

- Patient Information and Medical History Form
- Dental History Form
- Office Financial Policy and Missed Appointment and Cancellation Policy form
- Patient Health Information Policy (HIPAA) Form
- Dental Insurance Card
- If you have current x-rays and/or records at another office, they may email them to us at office@aridentistrynorthwest.com . Your previous dental office may require a signed release form you. We can assist you with this or with any records transfer from another office.

What to expect at your first appointment:

- At the time of your first appointment, we will listen closely to your concerns and conduct a thorough, comprehensive examination. We will take the time to give you the personal attention you deserve. In some cases an additional appointment may be required for completing the comprehensive assessment and providing a comprehensive treatment plan.
- Before any treatment begins, we will sit down with you and advise you of your options so you can make an informed choice regarding the best course of treatment for your specific needs. We respect our patients, and our goal is to provide you with the highest quality care in an atmosphere of mutual trust.

Thank you for choosing our practice to serve your dental needs. If you have any questions, please feel free to call us at (425) 771-2022.

Our entire staff is here to help you in any manner we can. We look forward to meeting you!

19020 33rd Avenue W • Suite200 • Lynwood, WA 98036
Phone – (425) 771-2022 • Fax (425) 775-9615
www.aridentistrynorthwest.com

Aesthetic Restorative & Implant
DENTISTRY NORTHWEST

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Date: _____

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
E-Mail: _____ Preferred Method of Contact: _____

Date of Birth: _____ Age: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Are you a student? ☐ Yes ☐ No Name of School: _____

Emergency Contact Name: _____ Phone Number: _____

Whom may we thank for referring you? _____

Account Information

Person Responsible for Account: _____ Relationship to Patient: _____

Your Name: _____
Social Security Number: _____
Employer: _____
Work Phone: _____

Spouse's Name: _____
Social Security Number: _____
Employer: _____
Work Phone: _____

Insurance Information

Primary Insurance: _____
Address: _____
Phone Number: _____
Group Number: _____
Carrier's Name: _____
Social Security Number: _____
Birth Date: _____
Employer: _____

Secondary Insurance: _____
Address: _____
Phone Number: _____
Group Number: _____
Carrier's Name: _____
Social Security Number: _____
Birth Date: _____
Employer: _____

Medical History BP:_____

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 recieve. Thank you for answering the following questions.

Are you under a physician's care now? Yes ◯ No ◯ If yes, please explain:_____
Have you ever been hospitalized or had a major operation? Yes ◯ No ◯ If yes, please explain:_____
Have you ever had a serious head or neck injury? Yes ◯ No ◯ If yes, please explain:_____
Are you taking any medications, pills or drugs? Yes ◯ No ◯ If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux? Yes ◯ No ◯ _____
Are you on a special diet? Yes ◯ No ◯ _____
Do you use tobacco? Yes ◯ No ◯
Do you use controlled substances? Yes ◯ No ◯

Women: Are you

Pregnant/Trying to get pregnant? Yes ◯ No ◯ Taking oral contraceptives? Yes ◯ No ◯ Nursing? Yes ◯ No ◯

Are you allergic to any of the following?

Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐

Other ☐ if yes, please explain: _____

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

AIDS/HIV Positive Yes ◯ No ◯	Cortisone Medicine Yes ◯ No ◯	Hemophilia Yes ◯ No ◯	Renal Dialysis Yes ◯ No ◯
Alzheimer's Disease Yes ◯ No ◯	Diabetes Yes ◯ No ◯	Hepatitis A Yes ◯ No ◯	Rheumatic Fever Yes ◯ No ◯
Anaphylaxis Yes ◯ No ◯	Drug Addiction Yes ◯ No ◯	Hepatitis B or C Yes ◯ No ◯	Rheumatism Yes ◯ No ◯
Anemia Yes ◯ No ◯	Easily Winded Yes ◯ No ◯	Herpes Yes ◯ No ◯	Scarlet Fever Yes ◯ No ◯
Angina Yes ◯ No ◯	Emphysema Yes ◯ No ◯	High Blood Pressure Yes ◯ No ◯	Shingles Yes ◯ No ◯
Arthritis/Gout Yes ◯ No ◯	Epilepsy or Seizures Yes ◯ No ◯	Hives or Rash Yes ◯ No ◯	Sickle Cell Disease Yes ◯ No ◯
Artificial Heart Valve Yes ◯ No ◯	Excessive Bleeding Yes ◯ No ◯	Hypoglycemia Yes ◯ No ◯	Sinus Trouble Yes ◯ No ◯
Artificial Joint Yes ◯ No ◯	Excessive Thirst Yes ◯ No ◯	Irregular Heartbeat Yes ◯ No ◯	Spina Bifida Yes ◯ No ◯
Asthma Yes ◯ No ◯	Fainting Spells/Dizziness Yes ◯ No ◯	Kidney Problems Yes ◯ No ◯	Stomach/Intestine Disease Yes ◯ No ◯
Blood Disease Yes ◯ No ◯	Frequent Cough Yes ◯ No ◯	Leukemia Yes ◯ No ◯	Stroke Yes ◯ No ◯
Blood Transfusion Yes ◯ No ◯	Frequent Diarrhea Yes ◯ No ◯	Liver Disease Yes ◯ No ◯	Swelling of Limbs Yes ◯ No ◯
Breathing Problem Yes ◯ No ◯	Frequent Headaches Yes ◯ No ◯	Low Blood Pressure Yes ◯ No ◯	Thyroid Disease Yes ◯ No ◯
Bruise Easily Yes ◯ No ◯	Genital Herpes Yes ◯ No ◯	Lung Disease Yes ◯ No ◯	Tonsilitis Yes ◯ No ◯
Cancer Yes ◯ No ◯	Glaucoma Yes ◯ No ◯	Mitral Valve Prolapse Yes ◯ No ◯	Tuberculosis Yes ◯ No ◯
Chemotheraphy Yes ◯ No ◯	Hay Fever Yes ◯ No ◯	Pain in Jaw Joints Yes ◯ No ◯	Tumors or Growths Yes ◯ No ◯
Chest Pains Yes ◯ No ◯	Heart Attack/Failure Yes ◯ No ◯	Parathyroid Disease Yes ◯ No ◯	Ulcers Yes ◯ No ◯
Cold Sores/Fever Blisters Yes ◯ No ◯	Heart Murmur Yes ◯ No ◯	Psyciatric Care Yes ◯ No ◯	Venereal Disease Yes ◯ No ◯
Congenital Heart Disorder Yes ◯ No ◯	Heart Pace Maker Yes ◯ No ◯	Radiation Treatments Yes ◯ No ◯	Yellow Jaundice Yes ◯ No ◯
Convulsions Yes ◯ No ◯	Heart Trouble/Disease Yes ◯ No ◯	Recent Weight Loss Yes ◯ No ◯	

Have you ever had any serious illnesses not listed above? Yes ◯ No ◯ If yes, please explain: _____

_____

COMMENTS

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect informations 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 _____

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Dr. Ariel Raigrodski, DMD, MS, FACP

Dental History

What is the most important thing we can do for you today? _____

Do you have any teeth that are sensitive to: **Hot** **Cold** **Sweets** **Brushing** **Biting?** (Circle all that apply)
Do you have any teeth that spontaneously **ache or throb**? YES NO If so, where? _____
Do you have any areas of the mouth that seem to **catch food**? YES NO If so, where? _____
Do you know if you **grind** your teeth while you sleep? YES NO
Do you wear an **appliance** at night when you sleep? YES NO
Do you know if you **clench** your teeth during the day? YES NO
Have you noticed your teeth **wearing dow**n at all? YES NO
Do you often suffer from: **headaches**? YES NO
Do you often suffer from **sore jaw muscles?** YES NO

Does your jaw joint ever **pop**, **click** or **get stuck** when you open? YES NO If so, how often? _____

Does your **bite ever feel different** when you wake up in the morning? YES NO If yes, how so? _____

When was the last time you saw a dentist for a **regular checkup** (best guess)? _____
Have you ever been told you have **gingivitis** or **periodontal disease (gum disease)**? YES NO
Do you have **dry mouth?** YES NO

How many times a year does your previous dentist recommend you have a professional "cleaning"?
(please circle) 2 3 4 other _____
Have you ever been treated by a **periodontist**? YES NO If yes, when? _____
Have you ever been treated by an **orthodontist**? YES NO If yes, when? _____

Do you have any **missing teeth** that have not been replaced? YES NO If yes, why? _____
Were there any recommended dental treatments that were never accomplished? YES NO
If so, what prevented it? _____
What are your future dental health **goals**? _____
If you could change anything about your smile, what would it be? _____
What has **prevented** you from making these changes? _____
What dental issues **not listed** would you like to discuss with the doctor? _____
What is your level of **dental anxiety**? (1-10 with 10 being the highest) _____
How would you rate your **current level of dental health**? (1-10 with 10 being the best) _____
When discussing treatment, would you prefer to have the "**big picture**" or would you like the "**details**"?_____
What is most important to you about the dental care you receive?_____
What else would you like to share with us regarding your care?_____

Signature (Guardian if patient is a minor) _____ Date: _____

Print Name_____

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Dr. Ariel Raigrodski, DMD, MS, FACP

Patient Health Information Policy

Patient Privacy & HIPAA (Health Insurance Portability and Accountability Act) Consent Form

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

• The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. Be assured that this office will limit the release of all Patient Health Information to the minimum needed for what the insurance companies require for payment.

• The patient has the right to examine and obtain a copy of his or her own records at any time.

• The patient's written consent need only to be obtained one time for all subsequent care given the patient in this office.

• The patient may provide a written request to revoke consent at any time during care. This would not effect the use of the records prior to the written request to evoke consent but would apply to any care given after the written request has been presented to our office.

• If the patient refuses to sign this consent for the purpose of treatment, payment, and healthcare options, we have the right to refuse to give care.

For your security and right to privacy, all staff have been trained in the area of patient information privacy. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

●I authorize that Dr. Ariel Raigrodski and staff are allowed to share my medical and dental

information, to use and disclose the protected health information as described to the following person/people:

Name_____ Phone #_____ Email:_____

Name_____ Phone #_____ Email:_____

Name_____ Phone #_____ Email:_____

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient, Parent, or Guardian signature _____Date _____ Time_____

Printed Name_____ Relationship _____

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Office Financial Policy

In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortable affordable, we are pleased to offer you these options for payment:

- A 5% bookkeeping courtesy is offered for payment in full with cash or check payment at or prior to completion of treatment services.
- For patients with insurance, your estimated portion is due at the time of service.
- For extended payments, we offer outside lending through Care Credit.

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addresses to your insurance carrier. Your deductible and patient portion must be paid at the time of service. Since dental plans vary widely in coverage, the estimated portion of your coverage may not be exact. As a guarantor, you will be responsible for services not covered by your policy.
I agree that I am fully responsible for the total payment of all procedures performed in this office- this includes any treatment that is not a benefit of my dental insurance that I may have.
One percent (1%) per month interest, twelve percent (12%) per year (per RCW 19.52) will be charged on accounts 90 days from treatment date.

Missed Appointment and Cancellation Policy

Please notify our office 2 business days (Monday through Thursday) or more in advance if you must reschedule your appointment.

- Any patient who cancels less than 24 business hours prior to their scheduled appointment will be charged a $95.00 late cancellation fee to their account.
- Any patient who misses or no shows their scheduled appointment will be charged a $130.00 no show fee to their account.
- This fee must be paid before a new appointment will be made. Patients with three missed appointments will be required to secure an appointment time by paying a $130.00 deposit prior to scheduling an appointment.

I have read and understood the Office Financial Policy, as well as the Missed Appointment and Cancellation Policy.
Patient, Parent, or Guardian's Signature _____ Date_____

Printed Name _____ Relationship_____

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