Dr. Neda Sayyah
Exceptional Cosmetic & General Dentistry
2000 116th Ave. NE, Suite 2
Bellevue, WA 98004
(425) 688-0197

Today's Date: _________

Patient's last name: ___________________ **First name:** _________________ **MI:** ___ **Nickname:** _________________

Phone (cell): ________________ **Phone (home):** _________________ **Email:** ________________________________

INSURANCE INFORMATION

1ST INSURANCE

Subscriber's Name: ________________________________

Soc. Sec. #: ________________ DOB: ________________

Street Address: ____________________________________

City, State, Zip: ____________________________________

Phone #: ______________________________________

Primary Insurance: ___________________________________

Group #: ____

Street Address: ______________________________________

City, State, Zip: ______________________________________

Phone #: ______________________________________

Relation to patient: ____Self ___Spouse
____Parent ___Other

UNION INFORMATION

Union Name: ________________ Local: ________

Union Phone #: ________________

Employer: __________________________________

Phone #: ______________________

Street Address: ______________________________

City, State, Zip: ______________________________

Relation to patient: ____Self ___Spouse
____Parent ___Other

2nd INSURANCE

Subscriber's Name: ________________________________

Soc. Sec. #: __________________ DOB: ________________

Street Address: ______________________________________

City, State, Zip: ______________________________________

Phone #: ____

Primary Insurance: ___________________________________

Group #: ____

Street Address: ______________________________________

City, State, Zip: ______________________________________

Phone #: ____

Relation to patient: ____Self ___Spouse
____Parent ___Other

UNION INFORMATION

Union Name: __________________ Local: _______

Union Phone #: __________________

Employer: ______________________________

Phone #: __________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Relation to patient: ____Self ___Spouse
____Parent ___Other

Signature: ____ Date: ______________

Neda Sayyah, DMD

Exceptional Cosmetic & General Dentistry

FINANCIAL POLICY

Our primary concern is for your health. For your convenience, listed below are the options available to address your financial needs.

Please read the following and sign.

To our insured patients: As a courtesy to you, we will submit your billing to most insurance carriers. However, your account is always your responsibility. Your insurance carrier has contracted with you to repay you a portion of your dental cost. Please remember, no insurance company attempts to cover 100 percent of all dental costs. It is your **responsibility** to pay any deductible or any balance not paid by your insurance carrier.

•All co-payments are due at the time of service unless other arrangements had been made previously with our financial coordinator.

For your convenience, we accept cash, check, Master Card, Visa and Discover Card. Patients in need of payment plan can inquire regarding DFP Plan.

Accounts over ninety (90) days outstanding will be considered overdue and acted upon for collection. A collection fee can be added to your account. A late fee of 1.0% per month is charged in overdue accounts.

Please let us know 48 hours in advance if you need to change your appointment, as this allows someone in need to use it. We **reserve** the right to charge for missed appointments.

I understand and agree to the above financial policy and will abide by the terms of the payment option indicated below.

Signature: ____ Date: __________________________

Payment options: (Indicate your choice)

__**Cash Payments:** Payment in full on each visit

__**Dental Insurance:** We ask that you pay your co-pay/percentage for every visit. We will submit your insurance for you and reimburse you for any credit balance we receive as a result of payment from your insurance carrier. We will do our very best to call and verify your dental benefits with your insurance company and discuss your coverage.

If after 60 days your insurance company has not initiated payment of benefits, you will be responsible for your account.

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NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the dental/health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the patient coordinator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

____ ____________

Signature of patient or authorized representative Date

____________________________ ______________________________

Printed name if signed on behalf of patient Relationship (parent, legal guardian, personal representative, etc.)

(Notation, if any, by staff)

This form will be retained in your medical record.

Neda Sayyah, DMD

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DENTAL COSMETIC AND RESTORATIVE INTERVIEW

Name: ________________________________

What prompted you to seek dental care at this time? ________________________________

When was your last dental appointment? ________________________________

What did you have done? ________________________________

Why did you leave your last dentist? ________________________________

What are you looking for in a dentist/dental office? ________________________________

____

Have you had any bad previous dental experience? ________________________________

Are you dissatisfied with the way your smile and teeth are in any way? ________________________________

____

Do you hide your teeth when you smile? ________________________________

Do you have any spaces you don't like? ________________________________

Do you have any fillings that show in your front teeth? ________________________________

If you could easily change one thing about your smile, what would it be? ________________________________

____

Would you whiten your smile, if it could be done safely and easily? ________________________________

Have you ever had any teeth removed? ________________________________

How long have these teeth been missing? ________________________________

Do you have an unpleasant taste or odor in your mouth? ________________________________

If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? ________________________________

Has the fear of discomfort kept you from regular dental visits? ________________________________

Are you deeply concerned about the finances required to return your mouth to excellent dental health? ________________

Do you have any other concerns about your teeth? ________________________________

THANK YOU, YOUR ANSWERS WILL HELP US ACHIEVE YOUR GOALS!