Patient Registration

Patient Name ____Today's Date: ___________________

Mailing Address ___________________________________Home Phone: ______________________

City________________State_____Zip:________Work Phone: ________________________________

Email: ___________________________________Cell Phone: _________________________________

Birth Date: ___/___/_____Age:_____ SSN: _____________________ Sex: Male Female

Marital Status: Single Married Widowed Divorced Spouses Name: ______________________

Emergency Contact: _________________Phone Number: __________________________________

Employer: ____

School: ____

Dentist: ____

How did you hear about our office? ____

Main Concern with your teeth or smile? ____

Responsible Party

Name: ____________________________ Relationship to Patient ___________________________

Marital Status: Single Married Widowed Divorced Spouses Name: _______________________

Mailing Address: ____________________________Home Phone: ____________________________

City: ________________State:_____Zip:________Work Phone: _____________________________

Employer: ____

Social Security: ____________________________Birth Date: _____ /_____ /___________________

Drivers License: ____________________ Custodial Parent: Yes No Other or N/A

Relationship to Patient: ____

Dental Insurance Information

INSURANCE PRIMARY: __________________ INSURANCE SECONDARY: ______________________

Employer: _____________________________ Employer: ___________________________________

Subscriber's Name: _____________________ Subscriber's Name: ___________________________

ID# or SS#_____________________________ ID# or SS#_____________________________________

DOB: _____________Group#_______________ DOB: ________________ Group#_________________

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes.

Patient Signature (parent if minor):____________________________Date:____________________

HEALTH HISTORY QUESTIONNAIRE

Northwest Family Dental Care 27081 185TH Ave S.E. Covington, Washington 98042

Name *(Last, First, M.I.)* :	☐ M ☐ F	**DOB:**
Height:	**Weight:**	

Are you in pain today? Where? Pain level 1-10?	☐ Yes	☐ No
Are you in good health?	☐ Yes	☐ No
Has there been any change in your general health in the past year?	☐ Yes	☐ No
Are you under physician's care for a particular problem?	☐ Yes	☐ No
Have you ever had any serious illnesses, operations, or hospitalizations? If so, describe…	☐ Yes	☐ No
When was your last physical exam? When was your dental exam?		

DO YOU HAVE OR HAVE YOU EVER HAD:		
Rheumatic Fever or Rheumatic Heart Disease?	☐ Yes	☐ No
Congenital Heart Disease or Bacterial Endocarditis (SBE)?	☐ Yes	☐ No
Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker, High Cholesterol)?	☐ Yes	☐ No
Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?	☐ Yes	☐ No
Seizures, Convulsions, Epilepsy, Fainting, or Dizziness?	☐ Yes	☐ No
Bleeding Disorder, Anemia, Hemophilia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?	☐ Yes	☐ No
Liver Disease (Jaundice, Hepatitis)?	☐ Yes	☐ No
Kidney Disease?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Thyroid Disease (Goiter)?	☐ Yes	☐ No
Arthritis?	☐ Yes	☐ No
Stomach Ulcers or Colitis?	☐ Yes	☐ No
Glaucoma?	☐ Yes	☐ No
Osteoporosis?	☐ Yes	☐ No
Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?	☐ Yes	☐ No
Radiation (X-ray) treatment for Cancer?	☐ Yes	☐ No
Chemotherapy treatment?	☐ Yes	☐ No
Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grinding or clenching teeth?	☐ Yes	☐ No
Sinus or Nasal problems?	☐ Yes	☐ No
Any disease, drug, or transplant operation that has depressed your immune system (i.e. - HIV/AIDS)?	☐ Yes	☐ No

ARE YOU USING ANY OF THE FOLLOWING?		
Antibiotics?	☐ Yes	☐ No
Anticoagulants (Blood Thinners)?	☐ Yes	☐ No
Aspirin or drugs such as Motrin, Aleve, or Ibuprofen?	☐ Yes	☐ No
High Blood Pressure medications?	☐ Yes	☐ No
Steroids (Cortisone, Prednisone, Anabolic, etc.)?	☐ Yes	☐ No
Tranquilizers?	☐ Yes	☐ No
Insulin or Diabetic drugs?	☐ Yes	☐ No
Digitalis, Inderal, Nitroglycerin or other heart drug?	☐ Yes	☐ No
Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma, or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)?	☐ Yes	☐ No
Have you ever been advised to NOT take a medication?	☐ Yes	☐ No

LIST ANY MEDICATIONS TAKEN, INCLUDING PRESCRIPTION, OVER THE COUNTER, VITAMINS OR MINERALS:		

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:		
Local Anesthesia (Novocaine, etc.)?	☐ Yes	☐ No
Penicillin or other antibiotics?	☐ Yes	☐ No
Sedatives, Barbiturates, or Benzodiazepines?	☐ Yes	☐ No
Aspirin or Ibuprofen?	☐ Yes	☐ No
Codeine or other pain killers?	☐ Yes	☐ No
Latex or Rubber products?	☐ Yes	☐ No
Metal of any kind?	☐ Yes	☐ No
Chemicals or jewelry (rash or sensitivity)?	☐ Yes	☐ No
Food products?	☐ Yes	☐ No
Please list any other allergies or reactions:		
Do you smoke or chew tobacco? If so, how much per day?	☐ Yes	☐ No
Do you have any history of Alcohol or Chemical Dependency?	☐ Yes	☐ No
Do you have any history of Emotional Disorders or Psychiatric Disorders that may affect the care we provide (i.e. - PTSD)?	☐ Yes	☐ No
Have you had any serious problems associated with any previous dental treatment?	☐ Yes	☐ No
Have you or an immediate family member had any problem associated with intravenous anesthesia?	☐ Yes	☐ No
Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?	☐ Yes	☐ No
Do you wish to talk to the doctor privately about anything?	☐ Yes	☐ No
Have you ever had a bone density scan?	☐ Yes	☐ No

WOMEN ONLY		
Are you Pregnant, or is there any chance you might be Pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
If you are taking Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.		

MEN ONLY		
Are you taking vasodilators for Erectile Dysfunction (i.e.- Viagra, Cialis, etc.)	☐ Yes	☐ No

I understand the importance of a truthful and complete Health History to assistant with my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist. ANY QUESTIONS I HAD ABOUT THIS FORM HAVE BEEN ANWERED AND I UNDERSTAND THE ANSWERS. I UNDERSTAND IT IS MY RESPONSIBILITY TO FILL OUT THE FORM CORRECTLY AND COMPLETELY.

SIGNATURE:	DATE:

Your “Smile” Questionnaire

Your Name________________________________**Date**___________________

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are (circle all responses):

Too small or short?	No	Yes
Too large or long?	No	Yes
Crooked or crowded?	No	Yes
Misshaped (uneven/pointed)?	No	Yes
Off Color?	No	Yes

Do you feel your front teeth **stick out too much (“Buck Teeth)**?
No Yes

Are there **spaces** between your teeth that you do not like?
No Yes

Is there **too much or too little gum tissue** showing when you smile?
No Yes

How do you feel about the size and position your lower jaw/chin?
Too short Just right Too long

Has there been **previous orthodontic treatment (including braces or other appliances)**?
No Yes
If so, when and by whom?
____

Are there other **dental issues not listed** above that you would like to discuss or have treated (such as TMJ problems, chewing problems, etc)? No Yes (explain)
____
____

Signature_________________________Relationship________Date_____________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Northwest Family Dental Care 27081 185TH Ave S.E. Covington, Washington 98042

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 by **Northwest Family Dental Care**, of the Notice of Privacy Practices, that contain 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 **Northwest Family Dental Care** 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.

Here at **Northwest Family Dental Care** the doctors and staff take digital photographs of patients for identification purposes and documentation of procedures. Photos may also be used for teaching and representation to train other staff and patients. These photos are never sold to a third party and no personal details (i.e. name or address) are ever accessible to the public. If you do not fully understand any of the above, please ask.

Patient Name: ___________________________________ Date: _________________________

Signature: ______________________________________

Relationship to Patient (if under 18): __________________________

Dependent family members also covered by this acknowledgement:

____

____

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the persons indicated below:

(Check one)

- ❑ Any member of the immediate family
- ❑ Spouse/Partner only
- ❑ Other (please specify)____

NOTICE OF PRIVACY PRACTICES

Northwest Family Dental Care 27081 185TH Ave S.E. Covington, Washington 98042

This notice describes how medial information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) required all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

Health Care Operations include the business aspects of running our practice.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use our confidential information to remind you of an appointment by sending reminder postcards, emails, text messages and/or leaving messages at home, work, and/or cell. Any other uses and disclosures will be made only with your written authorization.
You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below.

The right to request restrictions on certain uses and disclosures of protected health information from us by alternative means or at alternative locations.

The right to request to received confidential communication of protected health information from us by alternative means or at alternative locations.

The right to access, inspect, and copy your protected health information.

The right to request an amendment of your protected health information.

The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.

The right to obtain a paper copy of this notice from us upon request.

We require by law to maintain the privacy or your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June, 2003 and we are required to abide to the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the term of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the revised notice from this office.
You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filling a complaint.

For more information about your Privacy Practices, please contact for more information about HIPPA or to file a complaint:

Julie Hawken- Privacy Officer
Northwest Family Dental Care
27081 185th Ave Se, Suite B-105
Covington, WA 98042

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, D.C. 20201 877-696-6775