



PREMIER PERIODONTICS

Bellevue | Kirkland | Mercer Island | Redmond

PATIENT PERSONAL INFORMATION

Today's date:				Date reviewed/updated:		Initial here _____	
Title:	Last name:	First:	Middle:	Nickname:	Birth date:	Age:	
Address:				Cell Phone:		Marital Status:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
City, State, Zip:				Home Phone:		Work Phone:	
E-mail:			Referred by:				

Person responsible/guarantor for paying bills:

Title:	Last name:	First:	Middle:	Nickname:	Birth date:	Age:	
Address:				Cell Phone:		Marital Status:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
City, State, Zip:				Home Phone:		Work Phone:	

Do you have Primary Dental Insurance? Yes No **Do you have Secondary Dental Insurance?** Yes No

Group #:		Group #:	
Insurance Name:		Insurance Name:	
Phone #:		Phone #:	
Employer Name:		Employer Name:	
Subscriber's Name:		Subscriber's Name:	
Subscriber Address:		Subscriber Address:	
City, State, Zip:		City, State, Zip:	
Relationship to patient:	Subscriber DOB:	Relationship to patient:	Subscriber DOB:
Subscriber ID #:		Subscriber ID #:	

PATIENT MEDICAL INFORMATION

Allergies:			
Penicillin Y <input type="checkbox"/> N <input type="checkbox"/>	Sulfa Drugs Y <input type="checkbox"/> N <input type="checkbox"/>	Local Anesthetics Y <input type="checkbox"/> N <input type="checkbox"/>	Iodine Y <input type="checkbox"/> N <input type="checkbox"/>
Erythromycin Y <input type="checkbox"/> N <input type="checkbox"/>	Aspirin Y <input type="checkbox"/> N <input type="checkbox"/>	Codeine Y <input type="checkbox"/> N <input type="checkbox"/>	Latex Rubber Y <input type="checkbox"/> N <input type="checkbox"/>

Other Allergies:

Check yes or no:

Do you Pre-Medicate? Y <input type="checkbox"/> N <input type="checkbox"/>	Blood Transfusion Y <input type="checkbox"/> N <input type="checkbox"/>	Arthritis Y <input type="checkbox"/> N <input type="checkbox"/>	Cardiovascular/Heart Disease Y <input type="checkbox"/> N <input type="checkbox"/>	Congenital Heart Defect Y <input type="checkbox"/> N <input type="checkbox"/>	Mitral Valve Prolapse Y <input type="checkbox"/> N <input type="checkbox"/>
Alcohol/Drug Abuse Y <input type="checkbox"/> N <input type="checkbox"/>	Blood Clotting Problems Y <input type="checkbox"/> N <input type="checkbox"/>	Rheumatic Fever Y <input type="checkbox"/> N <input type="checkbox"/>	Congestive Heart Failure Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Attack Y <input type="checkbox"/> N <input type="checkbox"/>	High Blood Pressure Y <input type="checkbox"/> N <input type="checkbox"/>

Anemia Y <input type="checkbox"/> N <input type="checkbox"/>	Angina/Chest Pain Y <input type="checkbox"/> N <input type="checkbox"/>	Rheumatic Heart Disease Y <input type="checkbox"/> N <input type="checkbox"/>	Cardiac Pacemaker Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Murmur Y <input type="checkbox"/> N <input type="checkbox"/>	AIDS/HIV Infection Y <input type="checkbox"/> N <input type="checkbox"/>
Sexually Transmitted Disease Y <input type="checkbox"/> N <input type="checkbox"/>	Emphysema Y <input type="checkbox"/> N <input type="checkbox"/>	CPAP User Y <input type="checkbox"/> N <input type="checkbox"/>	Radiation/Chemotherapy Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes Y <input type="checkbox"/> N <input type="checkbox"/>	Hives Y <input type="checkbox"/> N <input type="checkbox"/>
Stroke Y <input type="checkbox"/> N <input type="checkbox"/>	Tuberculosis Y <input type="checkbox"/> N <input type="checkbox"/>	Sleep Apnea Y <input type="checkbox"/> N <input type="checkbox"/>	Stomach Ulcers Y <input type="checkbox"/> N <input type="checkbox"/>	Bulimia Y <input type="checkbox"/> N <input type="checkbox"/>	
Seizures Y <input type="checkbox"/> N <input type="checkbox"/>	Frequent Headaches Y <input type="checkbox"/> N <input type="checkbox"/>	Fainting Spells Y <input type="checkbox"/> N <input type="checkbox"/>	Thyroid Problems Y <input type="checkbox"/> N <input type="checkbox"/>	Dry Mouth/Sjogren Y <input type="checkbox"/> N <input type="checkbox"/>	
Bronchitis Y <input type="checkbox"/> N <input type="checkbox"/>	Sinus Trouble Y <input type="checkbox"/> N <input type="checkbox"/>	Lupus Y <input type="checkbox"/> N <input type="checkbox"/>	Joint Replacement Y <input type="checkbox"/> N <input type="checkbox"/>	Gag Reflex Y <input type="checkbox"/> N <input type="checkbox"/>	
Asthma Y <input type="checkbox"/> N <input type="checkbox"/>	Shortness of Breath Y <input type="checkbox"/> N <input type="checkbox"/>	Cancer/Tumor or Growth Y <input type="checkbox"/> N <input type="checkbox"/>	Kidney Disease Y <input type="checkbox"/> N <input type="checkbox"/>	Hay Fever Y <input type="checkbox"/> N <input type="checkbox"/>	

DENTAL QUESTIONNAIRE

Name of current dentist:

Reason for today's visit:

Last visit with your dentist:

Do you floss regularly?

Do your gums bleed while brushing or flossing?

Are your teeth sensitive to hot, cold or sweets?

Do you chew/smoke tobacco in any form?

Have you had any head, neck or jaw injuries?

Do you notice popping, clicking or soreness of your jaw?

Do you clench or grind your teeth?

Have you ever had orthodontic treatment?

Do you wear dentures or partials?

Have you ever been told you have gum disease?

Any disease, condition or problem not listed? Please list:

MEDICAL QUESTIONNAIRE

Family Physician:

Phone:

Are you currently under the care of your physician?

If yes, what is the condition being treated?

Have you had any serious illnesses, operations or have been hospitalized within the past 5 years? If yes, please explain:

Are you currently taking any medication? If so, please list:

_____	_____
_____	_____
_____	_____
_____	_____

Have you taken bisphosphonates? (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) Y N

Emergency Contact:

Emergency contact name/Relation to patient:

Phone:

Women Only:

Are you pregnant? Y N

Are you currently nursing? Y N

Are you on birth control pills? Y N

BY SIGNING BELOW, I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND TO THE BEST OF MY KNOWLEDGE.

Patient/Guardian Signature

Date

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights of 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* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy*.

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.

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 care information to the person(s) indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY

SPOUSE ONLY: _____

Other (please specify): _____

Patient Name: _____

Date: _____

Signature: _____