PREMIER
PERIODONTICS
ALWAYS HERE FOR YOU
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Bellevue
Everett
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: ☐ M ☐ 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: ☐ M ☐ F
City, State, Zip:	Home Phone:			Work Phone:		
Do you have Primary Dental Insurance? ☐ **Yes** ☐ **No**	Name of Current Insurance Carrier?					
Do you have Secondary Dental Insurance? ☐ **Yes** ☐ **No**	Name of Current Insurance Carrier?					

EMERGENCY CONTACT:	
Emergency contact name/Relation to patient:	Phone:

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 other dental issues?

PATIENT MEDICAL INFORMATION								
Check yes or no:								
Allergies:								
Penicillin	Y ☐ N ☐		Local Anesthetics	Y ☐ N ☐		Iodine	Y ☐ N ☐	
Sulfa Drugs	Y ☐ N ☐		Aspirin	Y ☐ N ☐		Latex Rubber	Y ☐ N ☐	
Erythromycin	Y ☐ N ☐		Codeine	Y ☐ N ☐				
Other Allergies:								
Kidney Disease	Y ☐ N ☐		Arthritis	Y ☐ N ☐		Stroke	Y ☐ N ☐	
Alcohol/Drug Abuse	Y ☐ N ☐		Rheumatic Fever	Y ☐ N ☐		Heart Attack	Y ☐ N ☐	
Congestive Heart Failure	Y ☐ N ☐		AIDS/HIV Infection	Y ☐ N ☐		Blood Transfusion	Y ☐ N ☐	
Blood Clotting Problems	Y ☐ N ☐		Rheumatic Heart Disease	Y ☐ N ☐		Heart Murmur	Y ☐ N ☐	
Emphysema	Y ☐ N ☐		Angina/Chest Pain	Y ☐ N ☐		Cardiac Pacemaker	Y ☐ N ☐	
Hives	Y ☐ N ☐		CPAP User	Y ☐ N ☐		Diabetes	Y ☐ N ☐	
Tuberculosis	Y ☐ N ☐		Stomach Ulcers	Y ☐ N ☐		Anemia	Y ☐ N ☐	
Mitral Valve Prolapse	Y ☐ N ☐		Sleep Apnea	Y ☐ N ☐		Bulimia	Y ☐ N ☐	
High Blood Pressure	Y ☐ N ☐		Fainting Spells	Y ☐ N ☐		Asthma	Y ☐ N ☐	
Cancer/Tumor or Growth	Y ☐ N ☐		Bronchitis	Y ☐ N ☐		Thyroid Problems	Y ☐ N ☐	
Frequent Headaches	Y ☐ N ☐		Sinus Trouble	Y ☐ N ☐		Lupus	Y ☐ N ☐	
Shortness of Breath	Y ☐ N ☐		Joint Replacement	Y ☐ N ☐		Seizures	Y ☐ N ☐	
Radiation/Chemo-therapy	Y ☐ N ☐		Dry Mouth/Sjogren	Y ☐ N ☐		Gag Reflex	Y ☐ N ☐	
Cardiovascular/Heart Disease	Y ☐ N ☐		Do you Pre-Medicate with Antibiotic?	Y ☐ N ☐		Hay Fever	Y ☐ N ☐	
Hepatitis: A, B or C	Y ☐ N ☐		Sexually Transmitted Disease	Y ☐ N ☐				

Have you had any serious illinesses, operations, been hospititalized in the last 5 years or any other medical issues or concerns not listed above?

Women Only:

Are you pregnant? Y ☐ N ☐	Are you currently nursing? Y ☐ N ☐	Are you on birth control pills? Y ☐ N ☐

MEDICAL QUESTIONNAIRE

Family Physician:	Phone:

Are you currently under the care of your physician?

If yes, what is the condition being treated?

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

_____ _____

_____ _____

_____ _____

_____ _____

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