Sammamish Highlands Family Dentistry

Patient Registration **Today's Date**

Patient Name:

Last First MI M F Birthdate

Address City State Zip

Home Phone Work Phone Cell Phone

Social Security # Would you like email reminders? Yes No

Email Address

Employer Address Years Employed

If Patient is a Minor: Parent or Guardian's Name:

Parent/Guardian Social Sec # Home Phone Work Phone

Family Members who are current patient's

Who may we thank for referring you to our office?

Primary Dental Insurance Info

Insured's Name B'date:

Insured's Employer

Insured's Social Sec # Group#

Insurance Co. Phone

Insurance Address

Patients Spouse

Name

Employer

Soc. Sec # B'date:

Secondary Dental Insurance Info

Insured's Name B'date:

Insured's Employer

Insured's Social Sec# Group#

Insurance Co. Phone

Insurance Address

Emergency Information

Relative not living with you

Name

Address

City State

Phone

Financial Agreement : I understand that I am financially responsible for all fees at the time of service. I understand that if I require special financial arrangements, I will talk with the Business Assistant and make payment arrangements.

Patients with Dental Insurance: Please note that insurance claims for each treatment will be processed through our office for 60 days, providing you supply us with current insurance information at each appointment and pay the remaining estimated percentage at the time of service. If after 60 days your insurance carrier has not paid on the claims, you will be responsible for full payment to John M. Rossi, DDS, at which time you can resume contact with your carrier to obtain reimbursement. If you require special financial arrangements, please indicate so to our Business Assistant and a financial plan will be created with you.

I have read the statement above and understand that I am financially responsible for services rendered at Dr. John M. Rossi's office

Signature Date

Patient Health History

Name: Birthdate: Date:

Please answer all questions to the best of your ability. Your health history will be held strictly confidential.

1) Are you under the care of a Physician?
   If yes, for what condition?
2) In the last 5 years have you: a) been hospitalized?
   b) had a serious illness? c) had a major operation?
3) Name and Phone number of your Physician:

Please check (X) if you have any of the following:

Allergies		Asthma		Anemia	
Diabetes		Epilepsy		Glaucoma	
Stroke		Heart Trouble		Heart Murmur	
Mitral Valve Prolapse		Heart Valve Replacement		Rheumatic Fever	
Low Blood Pressure		High Blood Pressure		Prolonged Bleeding	
Kidney Trouble		Sinus Trouble		Tuberculosis	
Persistent Cough		Multiple Sclerosis		Psychiatric Treatment	
Chemical Dependency		HIV Positive		Joint Replacement	
Oral Herpes		Hepatitis		Fainting Spells/Seizure	
Thyroid Condition		Type		Tumor	
Hyperactive / Hypoactive				Benign / Malignant	

Please check (X) any of the following you are taking:

Antibiotics		Insulin or similar drug		Nitroglycerin	
Anticoagulants		Oral Contraceptives		Cortisone/Steroids	
Tranquilizers		High Blood Pressure Meds		Antihistamine	
Aspirin		Heart Medication		Hormonal Therapy	
Herbal Supplements		OTC Meds		Other	

4) Women: Are you pregnant? If yes, how many months
5) Have you ever been "Pre-Medicated" with antibiotics prior to receiving dental treatment or have you been informed that you should be "Pre-Medicated"? Yes No Comments
6) Do you Smoke? Yes No How much? Do you use Smokeless Tobacco? Yes No

7) Are you Allergic or have you reacted adversely to any of the following?

Local Anesthetics		Penicillin/Antibiotics		Codeine/Narcotics	
Aspirin		NSAID (advil,aleve,motrin)		Latex	
Barbiturates		Sedatives/Sleeping Pills		Other	

8) Do you have any other illness or problems other than above that we should know?
   Yes, please explain?

I certify that the above information is true and correct.

Signed: Date: Dr.Rossi
(Parent or Guardian if under 18)

Dental History

Patient Name: Date:

Previous Dentist: City: Phone:

Approximate date of last dental visit: X-rays?:

YES	NO	Please answer the following questions
☐	☐	What is the most important thing you would like us to do for you?:
☐	☐	Are you presently in any dental pain?:
☐	☐	Have you ever had an unusual reaction to dental anesthetic?:
☐	☐	Have you experienced nitrous oxide or music sedation in the dental office?
☐	☐	Have you had orthodontic treatment? When?:
☐	☐	Have you lost any teeth? Reason:
		Were they replaced? Was is suggested?
☐	☐	Do you have any growths or swellings in your mouth?
		Where? How long existed?
☐	☐	Do you have any difficulties swallowing or chewing food?
☐	☐	Do you have unpleasant taste or odor in your mouth?
☐	☐	Do your gums bleed when brushing or flossing?
☐	☐	Is any part of your mouth sensitive to temperature, pressure, food or drink?
		What? Where?
☐	☐	Does food catch between your teeth? Where?
☐	☐	What is your past history of dental "recall" visits? (please check one)
		3mo. ☐ 4mo. ☐ 6mo. ☐ 12mo. ☐ Other
☐	☐	Have you ever been told that you have periodontal(gum)disease? When
☐	☐	Have you ever been to a Periodontist (Gum Specialist)?
		If YES, for what purpose?
☐	☐	Has anesthetic ever been used while having your teeth cleaned?
☐	☐	Do you brush? How often?
☐	☐	Do you floss? How often?
☐	☐	Is it difficult to floss between your teeth? Where?
☐	☐	Do you use any gum stimulator type devices:
		Stimudents ☐ Proxabrush ☐ Rubber tips ☐ Other
☐	☐	Have you ever been told that you have gum recession?
☐	☐	Do you have any pain or soreness around your eyes, ears, temples, or cheeks?
		Where/When?
☐	☐	Are you aware of stiff neck muscles? How Often?
☐	☐	Are you aware of clenching your teeth during daytime hours?
☐	☐	Have you ever been told you grind your teeth during sleep?
☐	☐	Are you aware of your jaw clicking or popping while eating or yawning?
		Do you have pain with this?
☐	☐	Do you have difficulty opening your mouth widely?
☐	☐	Do you have "tension" or "migraine" headaches? How often?
☐	☐	Have you ever been told that you snore?
☐	☐	Have you ever been told that you stop breathing or choke in your sleep?
☐	☐	Have you ever been told that you have a sleep disorder?
☐	☐	Are you dissatisfied with the appearance of you teeth? Color
		Shape Arrangement Other
☐	☐	Have you ever been told about tooth bleaching? Please describe
☐	☐	Have you been told about porcelain veneers? ☐ adult orthodontics? ☐
		Bonding ? ☐
☐	☐	What would you like your teeth to be like in 20 years :

Acknowledgement of Privacy Practices

Sammamish Highlands Family Dentistry
504 228th Ave NE
Sammamish, WA 98074
425-868-3887

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 (HIPPA). 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 Practices* and that I may contact this office at the address above and obtain a current copy of the *Notice of Privacy Practices.*

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.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

_____

For office use only:
We were unable to obtain the patients written acknowledgment of out *Notice of Privacy Practices* due to the following reason:

- ☐ The patient refused to sign _____
- ☐ Communication barriers _____
- ☐ Emergency situation _____
- ☐ Other _____