

## Patient Registration and health history

Patient's Name: \_\_\_\_\_ Name of Spouse/Parent: \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Address: \_\_\_\_\_  
 Birthdate, Age: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Address: \_\_\_\_\_ Email: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Email: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Work Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Work Address: \_\_\_\_\_ Responsible party if patient is a minor: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Relationship to minor: \_\_\_\_\_

Name, Address, and Phone of a relative NOT living with you: \_\_\_\_\_  
 \_\_\_\_\_

Please explain your reason for seeking dental treatment so we may best meet your needs: \_\_\_\_\_  
 \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

### Insurance: 1st Coverage

Employee Name: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Insurance Co.: \_\_\_\_\_  
 Group or Policy #: \_\_\_\_\_  
 Insurance Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_

### Insurance: 2nd Coverage

Employee Name: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Insurance Co.: \_\_\_\_\_  
 Group or Policy #: \_\_\_\_\_  
 Insurance Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_

**Assignment & Release:** I am financially responsible for payment at the time of service. I also authorize the dentist to release any information required for this claim.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** We cannot accept responsibility for collecting an insurance claim or for negotiating disputed claims. Insurance reimbursement is a contract between you and your insurance company. This office requires payment for services rendered at the time of service.

Your previous dentist: \_\_\_\_\_ How long? \_\_\_\_\_ Last dental x-ray date: \_\_\_\_\_

When was your last teeth cleaning by a Hygienist? \_\_\_\_\_ Cleanings per year: \_\_\_\_\_

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_ See your Dentist? \_\_\_\_\_

### Do you or have you ever had (circle all that are applicable)

|        |                         |        |                                      |        |   |
|--------|-------------------------|--------|--------------------------------------|--------|---|
| Yes/No | Head or neck injuries   | Yes/No | Anxiety over dental treatment        | Yes/No | Reaction to "Novocain"                            |
| Yes/No | Sore or sensitive teeth | Yes/No | Sores on lips/mouth are slow to heal | Yes/No | Bleeding/slow healing after an extraction         |
| Yes/No | Bleeding gums           | Yes/No | Orthodontic treatment                | Yes/No | Dissatisfaction with the appearance of your teeth |
| Yes/No | Grind or clench teeth   | Yes/No | Periodontal disease (Pyorrhea)       |        |   |
| Yes/No | Difficulty chewing      | Yes/No | Trouble opening/closing your jaw     |        |   |

Your Physician: \_\_\_\_\_ Type? \_\_\_\_\_ How Long: \_\_\_\_\_

Office Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Do you or have you ever had** (circle all that are applicable)

- Yes/ No Hospitalization for illness or surgery
- Yes/ No An allergic reaction
- Any reaction to:**
- Yes/ No Aspirin
- Yes/ No Penicillin
- Yes/ No Erythromycin
- Yes/ No Tetracycline
- Yes/ No Codeine
- Yes/ No Sedatives or sleeping pills (barbituates)
- Yes/ No Dental anesthetic
- Yes/ No Any other reaction
- Yes/ No Hepatitis
- Yes/ No Jaundice
- Yes/ No Epilepsy
- Yes/ No Arthritis
- Yes/ No Rheumatic fever
- Yes/ No Anemia or other blood disorders
- Yes/ No Prolonged bleeding due to a small cut
- Yes/ No Kidney disease
- Yes/ No Stomach or duodenal ulcer
- Yes/ No Liver disease
- Yes/ No Tuberculosis
- Yes/ No Emphysema
- Yes/ No Thyroid or parathyroid disorders
- Yes/ No Heart trouble/ murmur
- Yes/ No Joint replacements/ Pins
- Yes/ No Arteriosclerosis
- Yes/ No High Blood Pressure/ Low Blood Pressure (circle)
- Yes/ No Excessively swollen ankles
- Yes/ No Stroke

- Yes/ No Shortness of breath on mild exertion
- Yes/ No Chest pains on mild exertion
- Yes/ No Hives, skin rash, hay fever
- Yes/ No Asthma
- Yes/ No Emotional problems or tension
- Yes/ No Psychiatric treatment
- Yes/ No Tumor or abnormal growth
- Yes/ No Radiation treatment (cobalt, radium, x-ray, etc.)
- Yes/ No Glaucoma
- Yes/ No HIV+
- Yes/ No Prostate disorders (if male)
- Yes/ No AIDS (Acquired Immune Deficiency Syndrome)
- Yes/ No Venereal Disease

**Are You**

- Yes/ No Presently being treated for any illness
- Yes/ No Aware of a change in your health in the past year
- Yes/ No Aware of any recent weight change
- Yes/ No Often thirsty
- Yes/ No Urinating more than 6 times a day
- Yes/ No Often exhausted and fatigued
- Yes/ No Subject to frequent headaches
- Yes/ No A heavy smoker (1 or more packs of cigarettes a day)
- Yes/ No Generally a nervous person
- Yes/ No Often unhappy and depressed

**If female, are you**

- Yes/ No Pregnant
- Yes/ No Taking birth control pill or other hormones
- Yes/ No Presently in Menopause ("change of life")
- Yes/ No Post Menopause

Please explain any yes answers above, and list any medications you are taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If there are any changes in my medical history, I will **notify the Dentist.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Dr. Signature \_\_\_\_\_ Date \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **Date** \_\_\_\_\_ **Reviewed by:** \_\_\_\_\_ **Date** \_\_\_\_\_

consent for use and disclosure  
of health information

**Section A:**

Patient gives consent

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Patient Number: \_\_\_\_\_ SS# \_\_\_\_\_

**Section B:**

Please read caefully

**Purpose of Consent:**

by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:**

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at anytime by contacting the Contact Person listed in the left colume.

**Contact Person:**

S. David Buck D.D.S.  
310 Harvard Ave E  
Seattle, WA 98102

206.324.1100

**Right to Revoke:**

You will have the right to revoke this Consent at anytime by giving us written notice of your revocation submitted to the Contact Person listed here. Please understand that the revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, \_\_\_\_\_, have had a full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**Note:**

You are entitled to a copy of this Consent after you sign it.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

acknowledgement of receipt  
of notice of privacy practices

**Note:**

You may refuse to  
sign this  
acknowledgement

I, \_\_\_\_\_, have received a copy of this office's  
Notice of Privacy Practices.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

\_\_\_\_\_ Individual refused to sign

\_\_\_\_\_ Communications barriers prohibited obtaining the acknowledgment

\_\_\_\_\_ An emergency situation prevented us from obtaining the acknowledgement

\_\_\_\_\_ Other (please specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_