

PATIENT REGISTRATION QUESTIONNAIRE

DONALD G. SAMPSON, DDS

Your Family Dentist

6939 Littlerock Road SW, Suite B - Tumwater, WA 98512

(360) 352-0401

TODAY'S DATE _____

PATIENT'S NAME _____ BIRTHDATE _____
LAST FIRST MIDDLE

HOME ADDRESS _____ NAME OF SPOUSE/PARENT _____
STREET CITY STATE ZIP

HOME PHONE _____ BUSINESS PHONE _____ SOCIAL SECURITY NO. _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PRIMARY INSURANCE

INSURANCE COMPANY: _____ PHONE: _____

MAILING ADDRESS: _____ GROUP #: _____

SUBSCRIBER NAME: _____ SSN: _____

ADDRESS: _____ DOB: _____

EMPLOYER: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____ PHONE: _____

MAILING ADDRESS: _____ GROUP #: _____

SUBSCRIBER NAME: _____ SSN: _____

ADDRESS: _____ DOB: _____

EMPLOYER: _____

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 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 to 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: _____ Relationship to Patient _____

Signature: _____ Dependent family members also covered by this

Date _____ acknowledgement: _____

MEDICAL HISTORY

PHYSICIAN(S) _____

DATE OF LAST EXAMINATION BY PHYSICIAN _____ REASON FOR EXAMINATION _____

DO YOU NOW HAVE, OR HAVE YOU HAD IN THE PAST ANY OF THE FOLLOWING CONDITIONS:

	YES	NO
HIGH OR LOW BLOOD PRESSURE		
DIABETES		
HIV		
RHEUMATIC FEVER		
GONORRHEA		
SYPHILIS		
HERPES		
TB		
ARE YOU UNDER A PHYSICIAN'S CARE?		
ARE YOU TAKING ANY MEDICATION OR DRUGS?		
HAVE YOU EVER HAD A REACTION TO ANY DRUG OR MEDICATION?		
ARE YOU ALLERGIC TO ANYTHING?		
DO YOU USE TOBACCO? WHAT FORM? HOW MUCH?		
DO YOU USE ALCOHOL? HOW MUCH?		
HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING MEDICATION KNOWN AS BIOPHOSPHONATES; (FOR EXAMPLE ZOLEDRONIC ACID (ZOMETA) OR PAMIDRONATE (AREDIAL)?		
HAVE YOU NOTICED ANY CHANGES IN YOUR MOUTH, INCLUDING FOUL SMELL, SWELLING OR DISCHARGE?		

	YES	NO
HEART MURMUR		
ARTIFICIAL JOINT(S)		
KIDNEY OR LIVER DISORDERS		
CHRONIC INFECTIOUS DISEASE		
BLEEDING DISORDER		
ARTHRITIS		
EPILEPSY		
HEPATITIS A B C OTHER		
HEART DISEASE OR HEART SURGERY		
OTHER		
DO YOUR ANKLES SWELL DURING THE DAY?		
DO YOU HAVE SHORTNESS OF BREATH?		
DO YOU HAVE PAINS IN YOUR CHEST?		
WOMEN: ARE YOU PREGNANT?		
DO YOU TAKE BIRTH CONTROL PILLS OR HORMONE SUPPLEMENTS?		
HAVE YOU HAD A HYSTERECTOMY?		
ARE YOU POST MENOPAUSE?		

DENTAL HISTORY

DATE OF LAST DENTAL EXAMINATION _____

WAS YOUR TREATMENT COMPLETED _____

NAME OF PREVIOUS DENTIST _____

ADDRESS _____

DATE TEETH WERE LAST CLEANED _____

DATE OF LAST FULL MOUTH X-RAY _____

HOW OFTEN DO YOU HAVE YOUR TEETH CLEANED _____

DO YOU NEED ANESTHESIA? _____

	YES	NO
ARE YOU SATISFIED WITH YOUR PAST DENTAL WORK?		
ARE YOU AWARE OF ANY PARTICULAR DENTAL PROBLEMS?		
DID YOU HAVE FLUORIDE AS A CHILD?		
DO YOUR GUMS FEEL TENDER OR SWOLLEN?		
DO YOUR GUMS BLEED WITH NORMAL TOOTHBRUSHING OR FLOSSING?		

	YES	NO
DO HEAT, COLD OR SWEETS CAUSE PAIN IN YOUR MOUTH?		
DO YOU HAVE ANY OTHER PAIN IN YOUR MOUTH? INCLUDING JAW PAIN OR TOOTHACHE?		
DO YOU EVER HAVE PAIN AROUND OR IN YOUR EARS?		
HAVE YOU LOST ANY TEETH?		
HAVE YOU HAD NITROUS OXIDE USED DURING YOUR PRIOR DENTAL TREATMENT?		

WHAT DO YOU THINK OF YOUR TEETH? _____

WOULD YOU LIKE YOUR TEETH TO BE: WHITER? STRAIGHTER? SPACES CLOSED? MISSING TEETH REPLACED?

MY SIGNATURE CONFIRMS THAT THE ABOVE INFORMATION IS ACCURATE AND COMPLETE.

SIGNED _____ DATE _____