PATIENT REGISTRATION QUESTIONNAIRE

RICHARD C. DOWNING, DDS

Your Family Dentist

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(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 may 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 than 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 ______________