Patient Information

Name _____ Date of Birth __/__/____ Referred by _____

Address _____ City _____ Zip _____

Cell Phone _____ Home Phone _____

Email _____ Employer _____

Who is your general dentist? _____

Who is your primary care physician? _____

--please provide the following information, as needed, for insurance purposes --

Spouse's name _____ Spouse's Date of Birth ____/____/_____

Spouse's Employer _____ Spouse's Contact Info _____

Dental Insurance
(please indicate if the plan is yours or your spouse)

Primary Insurance _____ SSN/ID_____

Secondary Insurance _____ SSN/ID_____

Medical History

General Information

1. When was your last physical? _____
2. Do you see any medical specialists other than your PCP (e.g., cardiologist, oncologist, etc.)?

_____

_____

Allergies/Sensitivities (Check here if none [ ])

3. Are you allergic to any medications, food or latex? YES / NO

Please list all medication, food, or latex allergies:

_____

_____

4. Are you sensitive to any medications, food, or latex? YES / NO

Please list all medication, food, or latex sensitivities:

_____

_____

Medications (Check here if none [__])

5. Please provide us with a list of your current medications:

_____

_____

_____

6. Do you require antibiotics or other pre-medication before dental procedures? YES / NO

If so, what do you require? _____

7. Are you a current smoker? YES / NO

If yes, how many cigarettes a day do you smoke? _____

If yes, how long have you smoked cigarettes? _____

8. Do you have any history of alcohol or substance abuse/misuse? YES / NO

Please circle any of the following problems you have ever experienced

Cardiovascular Conditions (Check here if none [__])

Chest Pain | High Blood Pressure | Heart Murmur | Angina Pectoris | Rheumatic Fever

Pacemaker | Artificial Heart Valve | Mitral Valve Prolapse | Congenital Heart Lesions

Other/Comments: _____

Thyroid Conditions (Check here if none [__])

Hyperthyroidism | Hypothyroidism | Hashimoto's disease | Graves' disease | Goiter

Thyroid nodules | Other/Comments: _____

Immunodeficiency Problems/Infectious Disease (Check here if none [__])

HIV/AIDS | Hepatitis | Tuberculosis | Other/Comments: _____

Bone and Joint Conditions (Check here if none [__])

Joint replacement | Arthritis | Pain in joints | Osteoporosis | History of Bisphosphonate use

Implants | Other/Comments: _____

Respiratory Conditions (Check here if none [__])

Tuberculosis | Emphysema | Asthma | Sinus Problems | Cystic Fibrosis | Pulmonary Embolism

Other/comments: _____

Oncology/Cancer/Lesions (Check here if none [__])

Cancer/Tumor | Chemotherapy | Radiation treatment | Stomach Ulcers | Cold Sores

Other/Comments: _____

Blood Conditions (Check here if none [__])

Diabetes | Liver disease | Jaundice | Easy Bruising | Blood transfusion | Abnormal bleeding

Hemophilia | Anemia | Kidney trouble | Other/Comments: _____

Psychological/Neurological (Check here if none [__])

Psychiatric treatment | Anxiety disorder | Depression | Physical Limitation | Fainting Spells

Epilepsy | Stroke | Other Comments: _____

Do you experience any stress or anxiety when you go to dentist appointments? YES / NO

Additional Information/Comments

_____

_____

Emergency Contact and Patient Signature

In case of emergency, contact: Name_____

Relationship _____ Primary Phone _____ Other Phone _____

Patient's Signature _____ Date _____

Auburn Periodontics and Implantology
925 East Main Street
Auburn, WA 98002
253.833.2790

CONSENT FOR PERIODONTAL TREATMENT

I understand that I will be receiving recommendations for appropriate periodontal treatment. If I have any questions about any recommended treatment, I can ask for an explanation at any time. This is my consent to the treatment deemed or advisable and to the use of local anesthesia.

I understand that occasionally there are complications of the surgery, drugs, and anesthesia. The more common complications are pain, infection, swelling, bleeding, bruising and discoloration, temporary or permanent numbness and tingling of the lip, tongue, chin, gums, cheek, or teeth. More rarely, but occasionally occurring, are changes in the occlusion; temporomandibular joint discomfort; injury to adjacent teeth or other tissues; referred pain in the ear, neck or head; vomiting, allergic reactions; bone fractures and delayed healing. Sinus complications, which may include a nasal antral fistula or opening into the sinus from the mouth, may rarely occur.

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination which could be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle or hazardous devices or work while taking such medications and/or drugs or until fully recovered from the effects of the above.

I understand that there is no warranty or guarantee as to any result and/or cure.

_____ _____

Signature of Patient, Parent or Guardian Date

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Dr. Joseph Haynes DDS, PLLC. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Dr. Joseph Haynes DDS, PLLC reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	**☐ YES**	**☐ NO**
Any Member of my extended family: (Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other: _____	**☐ YES**	**☐ NO**
Name of patient (please print): _____		
Patient signature: _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ **Date:** _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

Joseph Haynes DDS PLLC
925 E. Main Street Auburn, Washington 98002 253-833-2790