

## 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.

<b>ADDITIONAL DISCLOSURE AUTHORIZATION</b>		
<i>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.)</i>		
Spouse only	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>OR</b>		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my extended family: (Parents, Grandchildren)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other: _____	<input type="checkbox"/> YES	<input type="checkbox"/> 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

<b>Acknowledgement Not Obtained</b>		
Provided Prior to Treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Date Statement Provided: _____		
Reason for not obtaining patient signature	<input type="checkbox"/>	Needed more time to review Statement
	<input type="checkbox"/>	Wanted to consult another person before signing
	<input type="checkbox"/>	Physically unable to sign
	<input type="checkbox"/>	No reason offered
	<input type="checkbox"/>	Other: _____

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