Implant & Periodontal Associates NW

Patient Registration

Patient Information: **Date: ____________________________**

Name: ____ DOB: ______________Social Security #:_________________

Address: ____ City: ___________________ Zip: ________________

Gender: Male Female Identify As: ________________ Marital Status: Single Married Divorced Widowed

Employer: _______________________________________ Occupation: ______________________________________

Work Phone: ______________________ Home Phone: ______________________ Cell Phone: ___________________

Email: ____

Spouse: ____________________________________ DOB: ____________________ SSN: _______________________

Employer: _______________________________________ Occupation: ______________________________________

Work Phone: _______________________ Home Phone: _____________________ Cell Phone: ___________________

If Patient is a minor, please complete the following:

Name of person responsible for this account: _______________________ Relationship to Patient: ___________________

Address: ____ City: _________________ Zip:________________

Cell Phone: ______________________________ Birthdate: ______________________ SSN: ______________________

Employer: ____________________________ Occupation: ___________________ Work Phone: ___________________

General Information:

General Dentist: _____________________ City: ______________ Orthodontist: ______________ City: ______________

Other people involved in dental care: ____

General Physician: ____ City: ______________________________

Dental Insurance Information:

Primary Ins. Company: _______________________

Policy Holder: ___________________ DOB:______

Relationship to Policy Holder: __________________

SSN or ID #: ________________________________

Group #: __________________________________

Employer: _________________________________

Secondary Ins. Company: ______________________

Policy Holder: ___________________ DOB:______

Relationship to Policy Holder: __________________

SSN or ID #: ________________________________

Group #: __________________________________

Employer: _________________________________

Implant & Periodontal Associates NW
140 Gage Blvd., Suite 200
Richland, WA 99352

T: 509.542.9111
F: 509.420.4912

Please see backside of this page!

Implant & Periodontal Associates NW

Medical & Dental Questionnaire

Although some of the following questions may seem unrelated to your teeth, they are associated with proper management of your oral health and are confidential.

Current Medications & Supplements:

____
____
____

Emergency Contact: ______________________________

Phone Number: _________________________________

Do you have or have you had any of the following:
(please circle yes or no)

Heart Problems Yes No
If yes, please describe: ________________________

High Blood Pressure Yes No

Low Blood Pressure Yes No

Pacemaker Yes No

Artificial Heart Valve Yes No

Joint Replacement Yes No
If yes, please describe: ________________________

Is an antibiotic premed required before treatment?
If so, what type/dosage: _______________________

Easy Bruising Yes No

Abnormal Bleeding Yes No

Anemia Yes No

History of Stroke/TIA Yes No

Asthma Yes No

Tuberculosis Yes No

COPD Yes No

Hepatitis, Type ______ Yes No

Osteoporosis Yes No

Osteopenia Yes No

History of Fainting Yes No

History of Seizures Yes No

Epilepsy Yes No

Other neurological disorder Yes No
If other, what: ______________________________

History of Head Trauma Yes No

Thyroid Concerns Yes No

Allergies & Symptoms:

____
____
____

Preferred Pharmacy:________________________________

If you could change anything about the appearance of your smile what would it be?

____

Diabetes, Type _____ Yes No
HbA1c: _______

Excessive Thirst Yes No

Dry Mouth Yes No

Oral Herpes of Cold Sores Yes No

HIV or
Acquired Immune Deficiency Syndrome Yes No

Have you ever been diagnosed with
the Human Papilloma Virus (HPV)? Yes No

Have you received the HPV vaccine? Yes No
(Gardasil or Cervarix)

Have you received an organ transplant Yes No

Have you had cancer Yes No
If yes, what type: ____________________________
If yes, medications/treatment: ___________________

Have you taken Fosamax/Boniva/Actone/Zometa Yes No

History of Alcohol Abuse Yes No

History of Drug Abuse Yes No

Do you smoke Yes No
If yes, how often: _______________

Women:
Pregnant, Due Date: ______________
Are you nursing Yes No
Contraceptives/Other Hormones Yes No

Men:
Do you take medications for Erectile Dysfunction Yes No
Do you have a history of prostate cancer Yes No

Other medical concerns/conditions we should be aware of:

____
____
____

Implant & Periodontal Associates NW
Patient Authorizations

Please initial below:

_______ ***I authorize*** the release of my dental records from Implant & Periodontal Associates and/or individuals involved in my dental care. I further authorize the release of records from any individuals to Implant & Periodontal Associates NW.

________ ***I authorize*** insurance payments to be made directly to Implant & Periodontal Associates NW. I understand I am responsible for any unpaid balance

________ ***I am aware*** that should I not provide adequate notice to change an appointment, I may be charged a fee. (7 calendar days for a surgical appointment and 2 business days for a cleaning appointment.)

________ ***I am aware*** of and have received notice of the Health Insurance Portability and Accountability Act (HIPAA).

Notice of Privacy Practice - Acknowledgment

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting us.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Authorization for Appointment Confirmation & Office Communications

As a courtesy to our patients, we often will give a variety of appointment reminders. Some of these reminders may generally include, but are not limited to, appointment post-cards sent through the mail, messages left with roommates/family members, voicemail messages, text messages, and emails. Usually within these reminders a certain amount of specific and detailed information, consisting of the patient's appointment time and date, or need for an appointment may be included.

By my signature below, I authorize Implant & Periodontal Associates NW and staff to confirm my appointments and remind me of the need for an appointment in the above-mentioned ways, for the duration of my treatment with their office.

Authorization to Discuss Treatment & Financial Information

By my signature below, I authorize Implant & Periodontal Associates NW and staff to discuss treatment and financial information with the people named below for the duration of my treatment with their office.

Name: ________________________ Relationship to Patient:_______________________ Cell Phone: _________________________

Name: ________________________ Relationship to Patient:_______________________ Cell Phone: _________________________

I do not authorize IPANW to discuss treatment and financial information with anyone other than myself._________(initials)

Printed Name: ____

Patient's Signature:____

Date: ____

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