Highland Family Dentistry

highlandfamilydds.com staff@highlandfamilydds.com
1710 Highland Drive • Prosser, WA 99350--1517 (509)786-1881

Patient Information Form

Please take a moment to enter or update your information to help us ensure the quality of care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Preferred method of contact

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Morning ☐ Afternoon ☐ Anytime

Name of person, office, or other source referring you to our practice:

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Medical and Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively in consideration for your overall health and well-being.

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contacts or glasses)?

☐ Do you wear hearing aids?

If any of the previous questions are marked, please explain:

_____

_____

WOMEN ONLY: Are you pregnant or nursing? ◯ Yes ◯ No

Please mark any that apply to you:

- [ ] Acid Reflux
- [ ] AIDS/HIV/STD'S
- [ ] Allergies/Augmentin
- [ ] Allergies/Hay Fever
- [ ] allergy
- [ ] Allergy/Amoxicillin
- [ ] Allergy/Codeine
- [ ] Allergy/Demerol
- [ ] Allergy/Erythromycin
- [ ] Allergy/Fentanyl
- [ ] Allergy/Latex
- [ ] Allergy/Morphine
- [ ] Allergy/Novacaine
- [ ] Allergy/Penicillin
- [ ] Allergy/Sulfa Drugs
- [ ] Allergy/Sulfites
- [ ] Allergy/Tetracycline
- [ ] Alzheimer's/Dementia
- [ ] Anemia
- [ ] Angina
- [ ] Arthritis/Rheumatism
- [ ] Artificial Joints
- [ ] Aspirin
- [ ] Asthma
- [ ] Asthma use inhaler
- [ ] Blood Thinners
- [ ] Cancer
- [ ] Chronic Bronchitis
- [ ] Defibulator
- [ ] Depression/Anxiety
- [ ] Diabetes
- [ ] Dizziness/Fainting
- [ ] Drug/Alcohol Abuse
- [ ] Eating Disorders
- [ ] Emphysema
- [ ] Epilepsy/Seizures
- [ ] fentanyl allergy
- [ ] Head Injuries
- [ ] Heart Murmur
- [ ] Heart Problems
- [ ] Heart Valves
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] latex
- [ ] lavokana
- [ ] lisinopril
- [ ] metforman
- [ ] Mitral Valve Prolaps
- [ ] msg
- [ ] Nitroglycern
- [ ] Pacemaker
- [ ] penicillin
- [ ] Psychiatric Problems
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers

Do you have any other health issues or allergies? *

Please list current prescription and non-prescription medications. *

How frequently do you brush your teeth?

☐ 3(+) / day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

How frequently do you floss your teeth?

☐ 1(+) / day ☐ 1-6 / week ☐ 1-6 / month ☐ Seldom ☐ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Are any of your teeth currently causing you pain?

☐ Do you have any issues with loose teeth?

☐ Do you use anything other than a toothbrush and floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

_____

_____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

☐ ***To the best of my knowledge, all of the preceding information is true and correct. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

HIPAA Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

?? Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
?? Obtaining payment from third party payers (e.g. my insurance company);
?? The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Please place your initials in the box indicating that you have read, understand, and give consent. *

Consent Form

I hereby certify that I have read and understand the previous information and that It is accurate and true to the best of my knowledge.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or gaurdian:

Signature _____ **Date** _____

Response Date: _____