37624 SE Fury Street • Suite 200
Snoqualmie, WA • (425)292-9230

Patient Registration Form

Please print clearly, answering *all* questions to ensure correct processing.
All information will be kept strictly confidential. Thank you.

Child's Name	Nickname	Birth Date	Age	❑ Male ❑ Female
Father's Name	Birthdate	Social Security #		❑ Stepfather ❑ Guardian
Current Mailing Address	City	State	Zip Code	
Father's Occupation	Employer	Home Phone	Work Phone	
❑ Married	❑ Single	❑ Divorced	❑ Separated	❑ Widowed
Mother's Name	Birthdate	Social Security #		❑ Stepmother ❑ Guardian
Current Mailing Address	City	State	Zip Code	
Father's Occupation	Employer	Home Phone	Work Phone	
❑ Married	❑ Single	❑ Divorced	❑ Separated	❑ Widowed
With whom does this child reside?				
Person responsible for child's account		Phone No.		

Insurance Information

Primary Dental Insurance

Employee	
Relationship to Patient	
Employer	
Insurance Co.	Group#
Social Security #	

Secondary Dental Insurance

Employee	
Relationship to Patient	
Employer	
Insurance Co.	Group#
Social Security #	

In case of emergency, whom may we contact?

Name	Home Phone	Work Phone
Relationship to Patient	Closest Relative	Phone No.

How did you hear about our office?

❑ Location	❑ Postcard	❑ Referral Card	❑ Office Website	❑ Hometown Values
❑ Phonebook	❑ Sno Valley Star	❑ Insurance	❑ Internet	❑ Other____________

Whom may we thank for referring you?

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Patient Name:____.

Dental History

Please print clearly, answering *all* questions to ensure correct processing.

Chief Chief dental concern: ______________________________

Is this your child's first dental visit? ❑ Yes ❑ No
Previous dentist's name______________________
Date of last visit:__________
Does your child feel nervous about having dental treatment? ❑ Yes ❑ / ❑ Yes ❑ No
Has your child ever had a bad dental experience? ❑ Yes ❑ No
Has your child been seen by an orthodontist? ❑ Yes ❑ No

Have there been any injuries to your child's teeth or jaws? Falls? Blows? Chips? etc? ❑ Yes ❑ No
Has your child ever been premeditated for dental work? ❑ Yes ❑ No
Does your child receive fluoride in vitamins, tablets, or water? ❑ Yes ❑ No

Health History

Is your child having pain or discomfort at this time? ❑ Yes ❑ No / ❑ Yes ❑ No
Has your child been hospitalized in the past 2 years? ❑ Yes ❑ No
Has your child been under the care of a medical doctor during the past 2 years? ❑ Yes ❑ No
Is your child currently taking any medication? ❑ Yes ❑ No
If yes, please list:______________________

Has your child taken any medications / drugs? ❑ Yes ❑ No
during the past 2 years? ______________________
If yes, please list: ______________________
____
Please list any serious medical condition(s) that your child has or has had: ______________________
____

Please Check "Yes or No" to the following conditions:

Y	N		Y	N		Y	N	
❑	❑	Angina Pectoris	❑	❑	Sickle Cell Disease	❑	❑	Emphysema / Asthma
❑	❑	Heart Disease / Attack /Stroke	❑	❑	Bruise Easily	❑	❑	Cough / Tuberculosis (TB)
❑	❑	Heart Failure	❑	❑	Hemophilia	❑	❑	Arthritis / Rheumatism
❑	❑	High / Low Blood Pressure	❑	❑	Liver Disease / Yellow Jaundice	❑	❑	Cortisone Medicine
❑	❑	Congenital Heart Defect	❑	❑	Kidney Failure/Disfunction	❑	❑	Venereal Disease
❑	❑	Heart Murmur / Rheumatic Fever	❑	❑	Thyroid Disease	❑	❑	A.I.D.S. / H.I.V.
❑	❑	Heart Surgery	❑	❑	Ulcers	❑	❑	Hepatitis: A B C (Circle one)
❑	❑	Heart Pacemaker	❑	❑	Glaucoma	❑	❑	Frequent Headaches
❑	❑	Artificial Heart Valve	❑	❑	Chemotherapy / Cancer	❑	❑	Pain in Jaw Joint
❑	❑	Diabetes	❑	❑	X-ray / Cobalt Treatment	❑	❑	Artificial Joints (Hip, Knee)
❑	❑	Blood Transfusion / Anemia	❑	❑	Cosmetic Surgery	❑	❑	Scarlet Fever
❑	❑	Fever Blisters / Cold Sores	❑	❑	Fainting / Dizzy Spells	❑	❑	Epilepsy / Seizures
❑	❑	Hay Fever / Sinus Trouble	❑	❑	Allergies / Hives	❑	❑	Shingles
❑	❑	Nervousness	❑	❑	Psychiatric Treatment	❑	❑	Drug / Alcohol Addiction

Notes:

Is your child allergic to or have you reacted adversely to the following?

Y	N		Y	N	
❑	❑	Antibiotics	❑	❑	Aspirin
❑	❑	Codeine	❑	❑	Latex
❑	❑	Metals / Jewelry	❑	❑	Local/Dental Anesthetic

Are you aware of being allergic to any other medications or substances? If yes, please list:
____
____
____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I give permission to A to Zzz Dental and its staff to perform the necessary dental services my child may need.

Parent/Guardian Signature

Signature______________________ Date__________
Comments______________________

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My Signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This information may be used via land line, cell phone, text message, email, fax, in person, or postal service. I understand that this information can and will be used to:

- *Provide and coordinate my treatment among a number of healthcare providers who may be involved in my treatment directly or indirectly.*
- *Obtain payment from third-party payers for my health care services.*
- *Conduct normal healthcare operations such as quality assessment and improvement activities, as well as appropriate communications with the patient.*

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 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 (NOPP). Importantly the updated 9/23/2013 version of the NOPP reflecting the OMNIBUS rule.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:**____Date:**________________________

***Signature:** __________________________**Relationship to Patient:**___________________________

**** Dependent family members also covered by this acknowledgement:***

____

Additional Disclosure Authority: (Discussion RE: Patient ect.)

OTHER- SPECIFY	Names	Signature	ID

_ _

For Office Use Only:

We were unable to obtain the patient's written acknowledgment of or Notice of Privacy Practices due to the following reason:

____The Patient refused to sign. **_____Communication barriers** **____Emergency situation** **____Other**