Professional
Perio Partners

REGISTRATION FORM

Patient Registration **Date**: ______________________________

Name:__________________________________ Birthdate:__________ Social Security #:______________________

Address:_______________________________________City:__________________________Zip:__________________

Gender: Male Female Marital Status: Single Sig Other Married Divorced Widowed

Employer:____Occupation:_________________________________

Phone Numbers: Home:___________________Work:______________________Cell:__________________________

Email address:______________________________Preferred method of confirmation:_________________________

Spouse/Partner:________________________Birthdate:______________Social Security #:_____________________

Employer:____Occupation:__________________________________

Work Phone:______________________Cell Phone:_________________________Email:________________________

If patient is a minor, please complete the following:

Name of person responsible for this account:____

Relationship to Patient: ____

Address:_______________________________________City:____________________________Zip:_______________

Birthdate:________________Social Security#:___________________________Home Phone: ___________________

Employer________________Occupation:___________________________Work Phone:________________________

General Information:

Patient's General Dentist:____

Patient’s Orthodontist:____

Other people involved in Care:____

Patients Physician:____Phone:__________________________________

Emergency Contact:____Phone: _________________________________

Preferred Pharmacy:____Phone:__________________________________

Insurance Information:

Primary Dental Coverage:

Insurance Company: ____________________________

Claims Address:_______________________________

Policy Holder:_________________________________

Birthdate:______________ID#___________________

Employer_______________Group#________________

Secondary Dental Coverage:

Insurance Company: ______________________________

Claims Address:___________________________________

Policy Holder: ____________________________________

Birthdate:______________ID#______________________

Employer_________________Group#________________

Primary Medical Coverage

Insurance Company: __________________________

Claims Address:_______________________________

Policy Holder:_________________________________

Birthdate:____________________________________

Employer________________________________

Group #_________________________________

ID#_____________________________________

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DENTAL HISTORY FORM

What is your immediate concern?

____

____

____

What is your estimation of your dental health? Excellent Good Fair Poor

Are you satisfied with the appearance of your teeth? Yes No

How long have you been with your present general dentist? ________________________________

I see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

Home care: Manual toothbrush Electric toothbrush Floss Proxabrush Waterpik

How often do you brush your teeth? ____

Have you ever had orthodontic treatment? Yes No

If yes, when? ____

Do you use a night guard? Yes No

Is there anyone with a history of periodontal disease in your family? _________________________

What are your goals and expectations of periodontal therapy?

____

Have you been anxious about having dental or periodontal treatment? Yes No

If yes, why? ____

Have you ever had any serious trouble associated with a previous dental experience?
Please specify:

____

Please list any other comments regarding your teeth, mouth, or dental history:_

____

____

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MEDICAL HISTORY FORM

Patient name:_________________________________ Date: ___________________________________

Do you have, or have you had, any of the following?
Please circle all that apply.

I. Skin
Itching ______________________________
Rash ______________________________
Ulcers ______________________________
Pigmentations___________________________
Lack or loss of body hair____________________

II. Extremities
Varicose veins___________________________
Swollen, painful joints_____________________
Muscle weakness, pain_____________________
Bone deformity, fracture____________________
Osteoporosis/Osteopenia (circle one)
Joint Replacements_______________________
Prosthetic joints_________________________
Type:_____________________________
Premed required/type:_____________________

III. Eyes
Blurring vision___________________________
Double vision____________________________
Drooping of eyelid________________________
Glaucoma_______________________________

IV. Ear, Nose, Throat
Dry Mouth____________________________
Earache________________________________
Frequent nosebleeds______________________
Sinusitis_______________________________
Frequent sore throat______________________
Hoarseness_____________________________

V. Respiratory
Sleep Apnea____________________________
Do you use a CPAP machine?______________
COPD_________________________________
Cough, blood in sputum___________________
Emphysema, bronchitis____________________
Wheezing, asthma________________________
Tuberculosis ____________________________

VI. Cardiac
Shortness of breath_______________________
Pain, pressure in chest______________________
Swelling of ankles________________________
Arrhythmia____________________________
High/low blood pressure____________________
Cholesterol_____________________________
Rheumatic or scarlet fever___________________
Heart Murmur, attack______________________
Prosthetic valves/pacemakers________________

VII. Gastrointestinal
Difficulty swallowing_________________________
Abdominal pain, ulcers_________________________
Hepatitis, jaundice____________________________
Liver disease_________________________________
GERD______________________________________

VIII. Genitourinary
Difficulty, pain on urination_____________________
Blood in urine_______________________________
Excessive urination___________________________
Kidney infections_____________________________
Sexually transmitted diseases____________________

IX. Endocrine
Thyroid Trouble________________________________
Weight change_______________________________
Diabetes/Type_________________________________
Result/Date most recent HbA1c:_________________
Excessive thirst_______________________________

X. Hematopoietic
Easy bruising, excessive bleeding_______________
Persistent lymphadenopathy____________________
G6PD deficiency_____________________________
Anemia____________________________________
HIV infection, AIDS__________________________
Leukemia, **problems with immune system_______________**
Spleen problems______________________________

XI. Neurologic
History of Head or Facial Trauma_______________
History of Stroke or TIA______________________
Frequent headaches___________________________
Dizziness, fainting____________________________
Epilepsy____________________________________
Neuritis, neuralgia____________________________
Tingling/Burning, numbness____________________
Paralysis____________________________________

XII. Psychiatric
Nervousness_________________________________
Irritability__________________________________
Depression, Anxiety___________________________
Nervous breakdown___________________________

XIII. Growth or Tumor
Radiotherapy/chemotherapy_____________________

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Do you smoke tobacco? Yes No If yes, how many years have you been smoking?____________
History of smoking? Yes No If yes, when did you quit smoking? _______________________
Do you use smokeless tobacco? Yes No
Do you consume recreational drugs? Yes No
History of alcohol or drug abuse? Yes No

Do you take or have you taken any of these medications?

Etidronate (Didronel) Tiludronate(Skelid) Neridronate Alendronate (Fosamax)
Ibandronate (Bondronat/Boniva) Risendronate (Actonel) Clodronate(Bonefos, Loron)
Pamidronate (Aredia) Olpadronate Zolendronate (Zometa)

List all medications/supplements you take and for what:

____

____

____

List all medications, foods, or materials that cause allergic reactions and symptoms:

____

Are you an organ donor/recipient? Yes No

Other diseases not listed? ____

Have you ever been diagnosed with or tested positive for COVID 19? Yes No
Have you received the COVID 19 Vaccine? Yes No

____

FOR WOMEN:
Pregnant/Due date: ______________________ Nursing: Yes No
Contraceptives/other hormones: Yes No
Have you noted a change in your menstrual pattern? Yes No
Menopausal/perimenopausal? Yes No

FOR MEN:
Do you have a history of prostate cancer/prostate enlargement? Yes No
Do you take medications for erectile dysfunction? Yes No

I certify that any and all questions I had about the inquiries above have been answered to my satisfaction. I was asked all of the questions on this form, and I have answered these questions truthfully and completely. I will not hold my dentist, or any other member his/her staff, responsible for any errors or omissions that I may have made.

Patient’s Signature: ____ Date: ______________

Parent’s/Guardian’s Signature (if applicable): ___________________________ Date: ______________

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FINANCIAL RESPONSIBILITY

Many patients have a commonly held misconception that medical and dental benefit policies that their employers, or they have purchased individually, will pay for all of their treatment. THAT IS INCORRECT AND UNTRUE.

As a patient in our office, you will receive treatment that is specific to the problems that are noted during your examination. Your doctor will carefully review his/her findings with you and explain to you the treatment options (if any) that are available to you. In return, your financial responsibility for the treatment that you agree to will be to the doctors' office. We will be glad to assist you in obtaining reimbursement for part of these benefits from your medical and/or dental insurance.

Often insurance companies, upon the patients' request, will send benefit reimbursement directly to the doctors' office. Please understand that your benefits contract will always have an allowable benefit payment for each procedure performed and that all allowable benefit is determined by the limitations of the contract that your employer or you have personally purchased from the insurer and does not always equal the doctor's submitted fee. Your insurance plan will pay only a percentage of the allowable benefit your employer or you have bought as part of your plan with a co-payment portion then being assigned to you. You are responsible to your doctor for payment of your yearly deductible, if not already satisfied, the patient co-payment portion, and any remaining portion of your doctor's bill that is not covered by your insurance plan.

We will be happy to discuss your financial arrangements for the payment of your bill and whether you have dental insurance available to you. Please understand that third party payment is NOT a guarantee of benefits payment, even though you may feel that you have the coverage under your insurance policies. Financial responsibility for all services received at this office is yours alone. We will gladly work with you to arrange payment for services provided, and these arrangements will be set up on an individual need's basis.

Thank you for your confidence in our office and our doctors. We look forward to providing you with exceptional care and courteous service.

I HAVE READ THE ABOVE FINANCIAL RESPONSIBILITY STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO PROFESSIONAL PERIO PARTNERS, DR. KATAFUCHI AND/OR ASSOCIATES,FOR ALL CARE AND SERVICES PROVIDED TO ME.

Patient's name: ____________________________Patient's Signature: ___________________________ Date: ______________
(If applicable)
Parent's/Guardian's name: __________________Parent's/Guardian's Signature: __________________ Date: _______________

AUTHORIZATIONS

I authorize the release of my dental records from Professional Perio Partners, Dr. Katafuchi and/or Associates, to individuals involved in my dental care. I further authorize the release of records from any individuals to Dr. Katafuchi and/or Associates.

I authorize release of medical information to insurance companies needed for the processing of claims.

I authorize insurance payments to be made directly to Professional Perio Partners, Dr. Katafuchi and/or Associates. I understand that,regardless of coverage, I am responsible for any unpaid balance on my account within 90 days from the date of service, and a **10% monthly fee will be assessed on any unpaid balance over 90 days.**

I authorize photos, slides, filming (including video patient testimonials), x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and/or Professional Perio Partners. My identity will not be revealed to the general public, unless authorized by me.

I am aware that should I not provide **three business days'** notice to change an appointment, I may be charged a fee of **$250 per hour for a surgical appointment and $100 per hour for an exam or hygiene appointment.**

I am aware of the Health Insurance Portability and Accountability Act (HIPPA) and will be provided a copy upon my request.

Patient's name: ____________________________Patient's Signature: ___________________________ Date: ______________
(If applicable)
Parent's/Guardian's name: __________________Parent's/Guardian's Signature: __________________ Date: ______________

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STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone - even family members - without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, text/email messages and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices is available for your review.

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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 if I do not fill this section out, my protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse Only

Any member of my immediate family (i.e., Spouse, Children, Siblings, etc.)

Any member of my extended family (i.e., Parents, Grandchildren)

Other individual(s): ____

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Professional Perio Partners. 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.

Professional Perio Partners 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 myfirst 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.

Patient’s name: ____

Patient’s signature: ____

Date: ____

Parent’s/Guardian’s name (If applicable): ______________________________

Parent’s/Guardian’s signature (If applicable): ___________________________

Date: ____