**Professional Perio Partners**

# REGISTRATION FORM

**PATIENT REGISTRATION** **Date:**

| Name: | Birthdate: | | SS #: |
|---|---|---|---|
| Gender: Male / Female | Marital Status: Single /Sig Other/ Married/ Divorced/ Widowed | | |
| Address: | City: | State: | Zip: |
| Employer: | | Occupation: | |
| Phone Numbers - Home: | Work: | | Cell: |
| Email address: | | | |
| Spouse/Partner Name: | Birthdate: | | SS #: |
| Employer: | | Occupation: | |
| Email: | Cell Phone: | | Work Phone: |

**If patient is a minor, please complete the following**

| Name of person responsible for this account: | | | |
|---|---|---|---|
| Relationship to Patient: | | | |
| Address: | City: | State: | Zip: |
| Birthdate: | SS#: | | Home Phone: |
| Employer: | Occupation: | | Work Phone: |

**General Information**

| Patient's General Dentist: | Phone: |
|---|---|
| Patient's Orthodontist: | Phone: |
| Other people involved in Care: | |
| Patients Physician: | Phone: |
| Emergency Contact: | Phone: |
| Preferred Pharmacy: | Phone: |

**Insurance Information**

| **Primary Dental Coverage:** | | **Secondary Dental Coverage:** | |
|---|---|---|---|
| Insurance Company: | | Insurance Company: | |
| Claims Address: | | Claims Address: | |
| Policy Holder: | | Policy Holder: | |
| Birthdate: | ID#: | Birthdate: | ID#: |
| Employer: | Group# | Employer: | Group# |

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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 months • 4 months • 6 months • 12 months • 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<br>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<br>If yes, why? |
| Have you ever had any serious trouble associated with a previous dental experience?<br>Please specify: |
| Please list any other comments regarding your teeth, mouth, or dental history: |

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### MEDICAL REGISTRATION FORM

| Patient name: | | | Date: | | |
|---|---|---|---|---|---|
| **Height:** | | | **Weight:** | | |
| Past | Present | | Past | Present | |
| | | **I. Skin** | | | **VII. Gastrointestinal** |
| ☐ | ☐ | Itching | ☐ | ☐ | Difficulty swallowing |
| ☐ | ☐ | Rash | ☐ | ☐ | Abdominal pain, ulcers |
| ☐ | ☐ | Ulcers | ☐ | ☐ | Hepatitis, jaundice |
| | | **II. Extremities** | ☐ | ☐ | Liver disease |
| ☐ | ☐ | Varicose veins | ☐ | ☐ | GERD |
| ☐ | ☐ | Swollen, painful joints | | | **VIII. Genitourinary** |
| ☐ | ☐ | Muscle weakness, pain | ☐ | ☐ | Difficulty, pain on urination |
| ☐ | ☐ | Bone deformity, fracture | ☐ | ☐ | Blood in urine |
| ☐ | ☐ | **Osteoporosis or Osteopenia** | ☐ | ☐ | Excessive urination |
| ☐ | ☐ | Joint Replacements: | ☐ | ☐ | Kidney infections |
| | | Date: | ☐ | ☐ | Sexually transmitted diseases |
| | | Premed Required: • Yes • No | | | **IX. Endocrine** |
| ☐ | ☐ | Parkinson's Disease | ☐ | ☐ | Thyroid Trouble |
| | | **III. Eyes** | ☐ | ☐ | Weight change |
| ☐ | ☐ | Blurring vision | ☐ | ☐ | Excessive thirst |
| ☐ | ☐ | Double vision | ☐ | ☐ | Diabetes / Type: |
| ☐ | ☐ | Drooping of eyelid | | | Last Date of HbA1c: |
| ☐ | ☐ | Glaucoma | | | Result of HbA1c: |
| | | **IV. Ear, Nose, Throat** | | | **X. Hematopoietic** |
| ☐ | ☐ | Dry Mouth | ☐ | ☐ | Easy bruising, excessive bleeding |
| ☐ | ☐ | Earache | ☐ | ☐ | Persistent lymphadenopathy |
| ☐ | ☐ | Frequent nosebleeds | ☐ | ☐ | G6PD deficiency |
| ☐ | ☐ | Sinusitis | ☐ | ☐ | Anemia |
| ☐ | ☐ | Frequent sore throat | ☐ | ☐ | HIV infection, AIDS |
| ☐ | ☐ | Hoarseness | ☐ | ☐ | Leukemia, problems with immune system |
| | | **V. Respiratory** | ☐ | ☐ | Spleen problems |
| ☐ | ☐ | Sleep Apnea | | | **XI. Neurologic** |
| ☐ | ☐ | Use of a CPAP machine | ☐ | ☐ | History of Head or Facial Trauma |
| ☐ | ☐ | COPD | ☐ | ☐ | History of Stroke or TIA |
| ☐ | ☐ | Cough, blood in sputum | ☐ | ☐ | Frequent headaches |
| ☐ | ☐ | Emphysema, bronchitis | ☐ | ☐ | Dizziness, fainting |
| ☐ | ☐ | Wheezing, asthma | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Tuberculosis | ☐ | ☐ | Neuritis, neuralgia |
| | | **VI. Cardiac** | ☐ | ☐ | Tingling/Burning, numbness |
| ☐ | ☐ | Shortness of breath | ☐ | ☐ | Paralysis |
| ☐ | ☐ | Pain, pressure in chest | ☐ | ☐ | Multiple Sclerosis |
| ☐ | ☐ | Swelling of ankles | | | **XII. Psychiatric** |
| ☐ | ☐ | Arrhythmia | ☐ | ☐ | Nervousness |
| ☐ | ☐ | High/low blood pressure | ☐ | ☐ | Irritability |
| ☐ | ☐ | High Cholesterol | ☐ | ☐ | Depression, Anxiety |
| ☐ | ☐ | Rheumatic or scarlet fever | ☐ | ☐ | Nervous breakdown |
| ☐ | ☐ | Heart Murmur | | | **XIII. Growth or Tumor** |
| ☐ | ☐ | **Heart Attack** | ☐ | ☐ | **Cancer** |
| ☐ | ☐ | Prosthetic valves/pacemakers | ☐ | ☐ | Radiotherapy/chemotherapy |

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| |
|---|
| Do you smoke tobacco? ☐ Yes ☐ No<br>If yes, how many years have you been smoking? |
| History of smoking? ☐ Yes ☐ No<br>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 taken bisphosphonates or anti-resorptive medications? Example: Prolia, Fosamax, Zometa, etc. ☐ Yes ☐ No |
| List all medications/supplements you take and for what: |
| |
| |
| |
| |
| |
| |
| |
| List all medications, foods, or materials that cause **allergic reactions** and symptoms: |
| |
| |
| Other diseases not listed: |
| |
| |
| |
| **FOR WOMEN:** |
| Pregnant? ☐ Yes ☐ No 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 of his/her staff, responsible for any errors or omissions that I may have made. |

| Patient's Signature: | Date: |
|---|---|
| Parent's/Guardian's Signature if minor: | |

## Professional Perio Partners
# FINANCIAL RESPONSIBILITY

- All patients must complete our information and insurance forms before being seen by the doctor. A copy of your driver's license will be obtained for identity verification.
- You are responsible for the full cost of treatment whether or not your insurance company pays or not. We will be glad to assist you in submitting dental insurance claims for treatment, but you must provide all dental insurance information **by your initial visit**. Most insurances require an ID# but please be aware that some require a social security number to process. We do not submit medical claims.
- Patient portion, deductibles, and any procedures not covered by your insurance plan remain your responsibility.
- **CANCELATION POLICY: Three business days' notice (this does not include Saturday, Sunday, Monday, or holidays) is required to change an appointment. A fee of $250 per hour for a surgical appointment and $100 per hour for an exam or hygiene appointment.**

**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 Signature: | Date: |
|---|---|
| Parent's/Guardian's Signature if minor: | |

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

| Patient's Signature: | Date: |
|---|---|
| Parent's/Guardian's Signature if minor: | |

# Professional Perio Partners
## 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.

**Professional Perio Partners**

## 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: | Date: |
| --- | --- |
| Patient's Signature: | |
| Parent's/Guardian's Name if minor: | Date: |
| Parent's/Guardian's Signature if minor: | |