CANYON PARK DENTAL

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Patient Registration
*Please Print and Answer **All** Questions*

GENERAL DENTISTRY
(425) 485-6540
(425) 486-1740-fax

Today's Date: _____

Patient's Name (Mr./Mrs.): _____ SS#: ____/____/____ Birthdate: _____ Sex: _____

Residence Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Occupation: _____ Employer: _____ Cell Phone: _____

Name of Spouse: _____ SS#: ____/____/____ Birthdate: _____

Occupation: _____ Employer: _____ Business Phone: _____

Responsible Party if Patient is a Minor: _____ Relationship to Minor: _____

Name, Address and Phone of Relative **NOT** Living with You: _____

_____

Party Responsible for Payment of Account: _____

INSURANCE 1ST COVERAGE

Employee Name: _____
Employer: _____
Name of Insurance Co: _____
Address: _____
Group #: _____
Member ID or SS #: _____
Birthdate: _____

INSURANCE 2ND COVERAGE

_____
_____
_____
_____
_____
_____
_____

ASSIGNMENT, RELEASE AND ACKNOWLEDGEMENT: *I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance due. I also authorize the dentist to release any information required for this claim. In addition, in consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.*

Additionally, my signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to: 1) Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly. 2) Obtain payment from third-party payers for my health care services. 3) Conduct normal health care operations such as quality assessment and improvement activities

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 such Notice of Privacy Practices. I understand that my dental provider has the right to change the 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.

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 health care 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's (or Authorized Representative) Signature: _____ Today's Date: _____

DENTAL HISTORY

How did you hear about our office?: _____

Your Previous Dentist: _____ City/State: _____ How Long?: _____

When was your last teeth cleaning by a hygienist?: _____ Cleanings per year?: _____

How often do you brush?: _____ Floss?: _____ See your Dentist?: _____

DO YOU HAVE OR HAVE YOU EVER HAD: *(Circle)*

1. Head or neck injuries..... Yes/No
2. Sore or sensitive teeth..... Yes/No
3. Bleeding gums..... Yes/No
4. Grind or clench teeth..... Yes/No
5. Difficulty chewing..... Yes/No
6. Anxiety of dental treatment..... Yes/No
7. Sores on lips/mouth that are slow to heal..... Yes/No
8. Dissatisfaction with appearance of your teeth..... Yes/No
9. Periodontal Disease (Pyorrhea)..... Yes/No
10. Trouble opening/closing your jaw..... Yes/No
11. Reactions to anesthetic ("Novocaine")..... Yes/No
12. Bleeding or slow healing after extraction..... Yes/No
13. Do you have any interest in cosmetic dentistry?..... Yes/No