

# CANYON PARK DENTAL

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**GENERAL DENTISTRY**  
(425) 485-6540  
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## Patient Registration

Please Print and Answer **All** Questions

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 1<sup>ST</sup> COVERAGE

Employee Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Name of Insurance Co: \_\_\_\_\_

Address: \_\_\_\_\_

Group #: \_\_\_\_\_

Member ID or SS #: \_\_\_\_\_

Birthdate: \_\_\_\_\_

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