TED HENNESSEY, DDS
REGISTRATION FORM
(Please Print)

Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Marital status: Other:___
Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: | Age: | Sex: ☐ M ☐ F

Street address: | Social Security no.: | Home phone no.: ( ) Cell Phone no.: ( )

P.O. box: | City: | State: | ZIP Code:

E-mail address: | Employer: | Occupation: | Employer phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box): ☐ Dr. ☐ Insurance plan ☐ Hospital
☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ | Secondary insurance ☐ | ☐ Other

Subscriber's name: (Primary ins.) | Subscriber's S.S. no.: | Birth date: | Group no.: | Policy no.: | Deductible: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Employer: | Group no.: | Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dental office. I understand that I am financially responsible for any balance. I also authorize Robert Eilert, DDS to release any information required to process my claims.

Patient/Guardian signature *Date*

DENTAL HISTORY

Name and address of Previous Dentist _____ Date of last dental visit _____
Why are you seeking dental treatment? _____
What is your estimation of your general dental health? _____
_____
Are you apprehensive about dental treatment? _____
Are you dissatisfied with the appearance of your smile? _____
Do you wear dentures? _____
Have you had any PERIODONTAL (GUM) treatments? _____
If so, when? _____ Where? _____
Do your gums BLEED, or feel TENDER or IRRITATED? _____
Are your teeth SENSITIVE to hot, cold, sweets, pressure? _____
Are you aware of GRINDING or CLENCHING your teeth? _____
Do you have DISCOLORED teeth that bother you? _____
Do you REGULARLY use DENTAL FLOSS? _____
Are you aware of any SWELLING or LUMPS in your mouth? _____
Have you ever had sores in your mouth or on your lips that were slow to heal? _____
Have you ever experienced a reaction to dental anesthetic? _____

MEDICAL HISTORY

Are you in good health? _____
Are you under a PHYSICIAN'S care now? _____
If so please explain. _____
Physician's name, _____ Address, _____ Ph# _____
Please list any medications taken within the past year _____
Please list: _____
_____
(Women) Are you pregnant? _____ If yes, # of weeks _____
Has a physician ever recommended that you pre-medicated prior to dental treatment? _____
If so, please explain, _____

Do you or have you had any of the following:

_____Heart problems, surgeries
_____High/Low blood pressure
_____Hepatitis
_____Bleeding disorder
_____Sinus problems
_____Allergies to Drugs
_____Allergies to anesthetic
_____Allergies_____
_____Other, please explain_____

_____Joint replacement/year? _____
_____AIDS/HIV positive
_____Scarlet Fever
_____Kidney/liver trouble
_____Rheumatic Fever
_____Psychiatric Care
_____Tuberculosis
_____Chemical dependency

_____Mumps
_____Stroke
_____Asthma
_____Anemia
_____Diabetes
_____Epilepsy
_____Arthritis
_____Herpes

Are you presently taking or ever been prescribed biophosphonates? (For example, Fosamax, Boniva, Actonel, Reclast or Miacalcin)
PLEASE CIRCLE:
NO YES _____
For how long?

_____
_____

It is important that I know about your Medical and Dental history. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone without your written permission.

DATE _____ YOUR SIGNATURE _____ REVIEWED BY _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

DR HENNESSEY
18218 52nd Ave W
Suite 200
Lynnwood, WA 98037

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:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers for my health care services.

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 to 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 Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

The patient refused to sign
Communication barriers
Emergency situation
Other