-Dr. Noreen Goldwire, DDS-

Patient Registration

Date _____

Name of Patient _____
First Middle Last Nickname

□ Male □ Female
□ Married □ Single □ Child Birth Date _____ Social Security # _____

Person Responsible for Account _____ Relationship to Patient _____

Home Address _____
Street City State Zip

Email Address _____

Home Phone_____ Work Phone_____ Cell Phone_____

Name of Your Employer _____ Occupation _____

Please complete this section if you would like us to submit to your dental insurance:

Name of Insurance Subscriber _____ Relationship to Patient _____

Insured's Birth Date Birth Date _____ Insurance ID# _____

Name of Insurance Company _____ Coverage Started _____

Address to send claims _____
Street City State Zip

Group/Policy # _____ Insurance Company Phone #_____

Do you have dental insurance coverage through any other plan? □ YES □ NO
(If yes, please provide the same information on separate paper)

Person to contact in case of emergency: _____
Name Phone

Names of immediate family members: _____

Who may we thank for referring you to our office? _____

-Dr. Noreen Goldwire, DDS-

Medical and Dental History (Page 1)

Date _____

Name of Patient _____ Age_____ Birth Date _____

Physician: _____
Name City/State Phone Number

Former Dentist:_____
Name City/State Phone Number

Date of Last Dental Exam: _____ Were any x-rays taken within the last year? Yes☐ No☐

Dental History

1. Do you have any dental problems or concerns at this time? Yes☐ No☐
   If yes, please complete: Where? _____ For How Long? _____
   Describe Symptoms _____
2. Are your teeth sensitive? Yes☐ No☐
3. Do you have any concerns about your gums? Yes☐ No☐
4. Can you chew comfortably Yes☐ No☐
5. Are you happy with the appearance of your teeth? Yes☐ No☐
   Would you like information on whitening Yes☐ No☐
   Would you like a smile analysis? (Evaluate tooth shape, position, color and smile symmetry) Yes☐ No☐
6. Have you ever had problems with local anesthesia (Novocain)? Yes☐ No☐
7. Have you ever had problems with dental treatment in the past? Yes☐ No☐
8. Is there anything special we can do to make your dental experience more comfortable? Yes☐ No☐

Headache History

Do you get headaches? Yes☐ No☐
   If yes, where is the pain located? _____
   How often do you get headaches? _____
   Please indicate your typical level of pain (low) 1 2 3 4 5 6 7 8 9 10 (high)
   Have the headaches been diagnosed? Sinus☐ Muscular☐ Vascular☐ Migraine☐ Stress☐
   If not diagnosed, what do you think is the cause? _____
   Have you used any medication? _____
   Have any treatments been tried? _____

TMJ

1. Pain in the joint itself? Yes☐ No☐ / Right☐ Left☐ Both☐
2. Clicking / Popping? Yes☐ No☐ / Right☐ Left☐ Both☐
3. Grating sound? Yes☐ No☐ / Right☐ Left☐ Both☐
4. How long have the symptoms been present? _____
5. Are your symptoms intermittent or constant? _____
6. Have your symptoms gotten better or worse? _____
7. Does anything make them worse? _____
8. Have you ever had a limitation of opening or closing your mouth? Yes☐ No☐
9. Have you had TMJ symptoms evaluated in the past? Yes☐ No☐

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Medical and Dental History (Page 2)

Patient Name: _____ **Birth date:** _____

Do you wish to use nitrous oxide for your treatment? (Typically not covered by insurance) Yes☐ No☐

Physician _____ Location/Phone _____

Have you travelled outside of the United States since your last visit? _____

Have you ever had any of the following diseases or medical problems? CIRCLE Y (Yes) N (No)			
Y N	A – V Shunt / CSF Shunt	Y N	HIV / AIDS
Y N	Allergies	Y N	Implants, any type
Y N	Anemia	Y N	Kidney Disease
Y N	Arrhythmia / Pacemaker	Y N	Organ Transplant / Asplenia (no spleen)
Y N	Artificial Joints	Y N	Osteoporosis
Y N	Asthma	Y N	Prolonged Bleeding / Blood Thinners
Y N	Autoimmune Disorders / Lupus	Y N	Prosthetic Heart Valves / Stents
Y N	Cancer / Chemotherapy / Radiation	Y N	Psychiatric Problems / Depression
Y N	Canker Sores	Y N	Recent Surgery
Y N	Central IV Catheter (Hickman)	Y N	Rheumatic Fever / Scarlet Fever
Y N	Cold Sores	Y N	Severe or Frequent Headaches / Migraines
Y N	Diabetes	Y N	Sinus Problems
Y N	Drug / Alcohol Abuse	Y N	Stomach Ulcers / Irritable Bowel
Y N	Emphysema / Respiratory Problems	Y N	Stroke / TIA
Y N	Epilepsy / Seizure / Fainting Spells	Y N	Thyroid Disorder
Y N	Heart Attack / Angina	Y N	Tobacco Use (if Yes, what type _____)
Y N	Heart Murmur / Mitral Valve Prolapse	Y N	Tuberculosis
Y N	Hepatitis: A, B, C	Y N	Venereal Disease
Y N	High / Low Blood Pressure		

♀ **For Women**: Are you: Pregnant? Yes☐ No☐ Nursing? Yes☐ No☐ Taking oral contraceptives? Yes☐ No☐

Please note any serious illnesses or conditions you have had not indicated above (use back of page if necessary):

_____

Please list any medications, vitamins, herbs, and/or over-the-counter medication?

_____ _____ _____

Are you allergic to any of the following? CIRCLE Y (Yes) or N (No)					
Y N	Asprin	Y N	Erythromycin	Y N	Sulfa
Y N	Codeine	Y N	Latex	Y N	Sedatives
Y N	Dental Anesthetics	Y N	Penicillin	Y N	Tetracycline
Please list any other drug or supplement allergies: _____					

Thank you for taking the time to complete your health history. We will hold this information in the strictest confidence. This vital information will help us provide you with the best possible care.

To the best of my knowledge the information I have given today is correct:

Sign_____Date_____

Sign_____Date_____

Sign_____Date_____

Sign_____Date_____

For Office Use Only:	
Date	Initial
_____	_____
_____	_____
_____	_____
_____	_____

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 Gayle K. James, DDS. 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.

Gayle K. James, DDS 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 my first 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.

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 the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: _____	☐ **YES**	☐ **NO**

YOUR CONTACT INFORMATION			
			√ ***YOUR PREFERRED NUMBER*** ↓
May we contact you at **CELL**?	☐ YES	☐ NO	Number: ☐
May we contact you at **HOME**?	☐ YES	☐ NO	Number: ☐
May we contact you on your **WORK**?	☐ YES	☐ NO	Number: ☐
May we contact you via **EMAIL**?	☐ YES	☐ NO	

Patient Signature: _____ Date: _____

Patient Name (PRINT): _____

If you are a parent of a minor, guardian, or personal representative fill out the following.
Patient's personal representative: (Please Print): _____
Personal Representative's signature:_____
Representative's Telephone Number: _____Date: _____

Dr. Noreen Goldwire, DDS
22232 17th Avenue SE, Suite 208 – Bothell, Washington 98021 - 425-485-4010

Statement of Privacy Practices

Dr. Noreen Goldwire, DDS

Our office is dedicated to protect 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 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, 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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