Name: _____ Date of Birth:____/____/_____

Address:_____ City:_____ State:_____ Zip_____

Best Contact Number: (____)_____-_____ Type: Cell Work Home

Secondary Number: (_____)_____-_____ Type: Cell Work Home

Email Address:_____

Occupation:_____

Circle One: Married Single Divorced Separated Widowed

Referred by:_____

Emergency Contact (Name, Number and Relationship):

_____

Medical History

Primary Physician:_____ Phone:(_____)_____-_____

Primary Dentist:_____ Phone:(_____)_____-_____

Are you presently under a physician's care? YES NO

Date of last physical? Month:_____ Year:_____

Have you been hospitalized or have a history of serious illness? YES NO

If YES, what for?:_____

Please describe any current medical treatment, impending surgery, pregnancies or other information the doctor should be aware of:

_____

Have you been advised to take antibiotics or other medication PRIOR to dental care? YES NO

If YES: Medication_____Reason:_____

Have you ever taken medication for Osteoporosis? YES NO

Medication:_____ Dosage:_____ Frequency:_____

Do you have any allergies? (i.e. Latex, Amoxicillin, Novocaine, ECT.)

If so, please list:_____

Is there anything you'd like us to know immediately about your current medical or physical condition?_____

Please list or attach your current medications (over the counter, prescribed and any vitamins) and the reason for taking the medication/vitamin.

Please circle correct response for the following medical history questions:
Y= YES, N=NO or U=UNSURE

Do you consider yourself cavity prone?	Y N U	Do you have any missing teeth other than wisdom teeth?	Y N U
Do you consume sugary foods or beverages on a regular basis?	Y N U	Do you ever experience discomfort when chewing?	Y N U
Do you consume any citrus flavored beverages or fruits?	Y N U	Do your jaw joints click, pop or make grinding sounds?	Y N U
Does your mouth feel dry?	Y N U	Do you experience frequent headaches or jaw/facial pain?	Y N U
Do you have heartburn or acid reflux?	Y N U	Do your joints ever get stuck or locked?	Y N U
Have you been told you have gingivitis or gum disease in the past?	Y N U	Have you ever been treated for a jaw joint problem?	Y N U
Do your gums ever bleed when you brush or floss?	Y N U	If so, by what methods:	
Do you have gum recession or exposed root surfaces?	Y N U	Do you wear any removable prosthetics, dentures or partials?	Y N U
Do you have any loose teeth, Drifting teeth or areas that collect food when you eat?	Y N U	If so, are they comfortable and well fitting?	Y N U
Do you smoke, vape or chew tobacco?	Y N U	Do you use adhesive?	Y N U
Do you have any persistent sore spots in your mouth or lumps/bumps in your head or neck?	Y N U	Do you wish you felt better cared for or more trusting of your medical team?	Y N U
Do you feel as if you have a lump in your throat?	Y N U	Do you seek annual preventive services?	Y N U
Recognizing that HPV infection is the single biggest risk factor for oral/pharyngeal cancer, would you like to be tested for HPV?	Y N U	Are you currently being treated for high blood pressure or cardiovascular disease?	Y N U

Have you had any heart valves replaced?	Y N U	Are you currently undergoing cancer treatment?	Y N U

Do you have a history of heart attack, stroke, bypass surgery or stints?	Y N U	Do you have any known risk factors for a specific cancer?	Y N U
Do you experience shortness of breath or chest pain?	Y N U	Are you aware of any chronic inflammatory conditions such as irritable bowel syndrome, fibromyalgia, arthritis, chronic fatigue syndrome, insulin resistance, or periodontal/gum disease?	Y N U
Do you have a family history of heart disease?	Y N U	If yes, please list:	
Do you take anti-cholesterol medicine?	Y N U	Have you ever tested positive for hepatitis, HIV+, AIDS or any STD?	Y N U
Have you ever been diagnosed or treated for high blood pressure?	Y N U	If so, what?	
If so, is it currently controlled?	Y N U	To your knowledge, are you currently pregnant?	Y N U
Do you currently take blood pressure medicine?	Y N U	Do you have Type 1 or Type 2 Diabetes?	Y N U
Do you monitor your own blood pressure?	Y N U	Do you have excessive bleeding?	Y N U

If this is an update to your current medical history or medications please initial and date on the updated line below:

Updated _____Updated_____ ***Updated_____

Signature: _____ Today's Date: _____

Staff Name: _____ Today's Date: _____

ADMIN ONLY □Driver's License □Insurance Card □Medication List

STATEMENT OF PRIVACY PRACTICES

PETRINI PROSTHODONTICS

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, 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.

Petrini Prosthodontics
221 SW 155th Street Burien, Washington 98166 | 206-242-6660

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Petrini Prosthodontics. 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.

Petrini Prosthodontics 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 each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	**☐ YES**	**☐ NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other:	**☐ YES**	**☐ NO**

Name of patient (please print):

Patient signature:

Patient's personal representative: (Please Print):

Personal Rep's signature:

Representative's Phone Number: **Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided:**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

PETRINI PROSTHODONTICS

221 SW 155th St
Burien, WA 98166
206-242-6660
office@petriniprosthodontics.com
Dr. John J Petrini, DDS, MS, FACP

In preparation for our time together, we have enclosed the following questions that may help you identify items of discussion for your initial visit.

What do you hope to accomplish from your first appointment with us?

Please think about your previous dental experiences. What positive experiences would you like to find in our practice?

What experiences would you like to avoid?

What are the main issues or challenges you'd like us to help you with?

What are the time, financial or other considerations you'd like us to understand?

What else would you like us to know in order to help you most effectively?

Thank you for taking the time to help us assist you with your exam today. We look forward to meeting you and giving you exceptional patient care.

Dr. Petrini is a Fellow of the American College of Prosthodontists

Website: www.petriniprosthodontics.com

Admin only: Patient Name_____ Date_____