Otis R. Washington, D.D.S., M.S., P.A.
Diplomate of the American Board of Periodontology

2310 Myron Drive
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P: (919) 782-9536
F: (855) 787-8025

Name:		SSN:
Date of Birth (mmddyy):	Sex: ☐ Male ☐ Female	
Address		
Home ☎ ( )	Work ☎ ( )	
Email address:	Pager or Cell ( )	
Height: Weight: Blood Pressure:		
Occupation:	Employer:	
Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated		
Spouse's Name:	Spouse's Date of Birth:	Spouse's SSN:
Spouse's Employer:	Spouse's Work ☎ ( )	
Nearest Friend or Relative Not Living With You:		
Relationship:	Phone ☎ ( )	
Who may we thank for referring you?		

Insurance Information

Name of Insured:		Relationship:
Insured's SSN:	Date of Birth (mmddyy):	
Employer:		
1) Name of Primary Insurance Company:		
Subscriber:	Policy #/Group #	
2) Name of Secondary Insurance Co.:		
Subscriber:	Policy #/Group #	

Responsible Party *If someone other than the patient is responsible for the payment of services.*

Name of Person Responsible for Account:	
Relationship to Patient:	
Address	
Home ☎ ( )	Date of Birth (mmddyy):
Employer:	Work ☎ ( )

I have completed this form to the best of my ability, and certify that I am the patient or duly authorized to represent the patient & furnish the requested information. I understand that though I may have insurance coverage, I am responsible for payment in full at the time services are rendered unless prior arrangements have been made.

* **Signature of Patient, Parent, or Responsible Party:** _____ **Date:** _____

* Preferred Method of Payment: ☐ Cash ☐ Check ☐ Credit Card
(We accept: Master Card, Visa, American Express, Discover & Care Credit in addition to cash & personal checks.)

Notes:

Welcome to Our Practice!

Dear Patient: The following information about your health history is necessary in order to provide you with the best possible care in a safe way. Incorrect information may be dangerous to your health. **ALL** questions must be answered completely and accurately. If you do not understand a question, or are unsure of the answer, or want to discuss it with Dr. Washington, circle or mark it. This Health History Questionnaire will become a part of your dental treatment record and will be considered confidential information. Thank you.

Patient Medical History

Name of Physician:	Phone ☎
Address 🖃	
Name of Dentist:	Phone ☎
Address 🖃	

Family History *Please list any disease or condition which may apply within your family.*

Mother:	Sibling(s):
Father:	Others:

Health

1. Are you in good health?				☐ Yes ☐ No ☐ Unsure
2. Have there been any changes in your health in the last year?				☐ Yes ☐ No ☐ Unsure
3. Have you ever been hospitalized, had a major operation or serious illness?				☐ Yes ☐ No ☐ Unsure
4. Date of your last visit to your doctor?			Reason:	
5. Are you currently receiving treatment or regular medical care by your doctor?				☐ Yes ☐ No ☐ Unsure
* If you answered "yes" for any of the above, please explain:				
6. Are you taking any of the following medications?				
	☐ Antibiotics or sulfa drugs	☐ Birth control pills or hormones	☐ Insulin or other drugs for diabetes	☐ Tranquilizers
	☐ Anticoagulant (blood thinners)	☐ Cortisone (steroids)	☐ Nitroglycerin	☐ Others, please list:
	☐ Antihistamine	☐ Digitalis or drugs for heart trouble	☐ Pain medicines or anti-inflammatories	
	☐ Aspirin	☐ High blood pressure medicine	☐ Synthroid or other thyroid medication	
7. Are you allergic to or have you had any unusual reactions to any medications or anesthetics?				☐ Yes ☐ No ☐ Unsure
* If yes, what medications and reactions?				
Have you ever had or been treated by a doctor for any of the following?				
8. HEART PROBLEMS: Damaged or artificial heart valves, heart murmur, rheumatic fever, rheumatic heart disease, congenital heart problems or heart attack?				☐ Yes ☐ No ☐ Unsure
* Have you ever been required to pre-medicate prior to dental procedures?				☐ Yes ☐ No ☐ Unsure
9. High blood pressure or stroke?				☐ Yes ☐ No ☐ Unsure
a. Do you have pain in your chest upon exertion?				☐ Yes ☐ No ☐ Unsure
b. Are you ever short of breath after mild exercise?				☐ Yes ☐ No ☐ Unsure
c. Do your ankles swell?				☐ Yes ☐ No ☐ Unsure
10. Severe or frequent headaches or sinus problems?				☐ Yes ☐ No ☐ Unsure
11. Blood disorders such as anemia or hemophilia?				☐ Yes ☐ No ☐ Unsure
12. Breathing problems, emphysema, tuberculosis or other lung problems?				☐ Yes ☐ No ☐ Unsure

13. Asthma, hay fever or hives?	☐ Yes ☐ No ☐ Unsure
14. Stomach or intestinal disease, or ulcers?	☐ Yes ☐ No ☐ Unsure
15. Cancer, x-ray treatments, or chemotherapy?	☐ Yes ☐ No ☐ Unsure
16. Diabetes or blood sugar problems?	☐ Yes ☐ No ☐ Unsure
17. Hepatitis, jaundice, or liver disease?	☐ Yes ☐ No ☐ Unsure
18. Kidney infections, frequent urination, or renal (kidney) dialysis?	☐ Yes ☐ No ☐ Unsure
19. Seizures, fainting spells, numbness or other neurologic problems?	☐ Yes ☐ No ☐ Unsure
20.AIDS, AIDS-related condition or HIV positive?	☐ Yes ☐ No ☐ Unsure
21. Tumors or growths?	☐ Yes ☐ No ☐ Unsure
22. Arthritis or rheumatism?	☐ Yes ☐ No ☐ Unsure
23. Phobias, severe anxieties, depression, unusual fears, or mental problems?	☐ Yes ☐ No ☐ Unsure
24. Psoriasis, seborrhea, or other skin diseases?	☐ Yes ☐ No ☐ Unsure
25. Have you lost weight without dieting or gained weight in recent months?	☐ Yes ☐ No ☐ Unsure
26,Do you have complaints regarding your eyes, ears, or nose?	☐ Yes ☐ No ☐ Unsure
27. Do you wear contact lenses?	☐ Yes ☐ No ☐ Some
28. Do you now use or have you ever used recreational drugs?	☐ Yes ☐ No ☐ Unsure
29. Do you smoke tobacco? ☐ Cigarettes ☐ Cigars ☐ Pipes	☐ Yes ☐ No ☐ Some
How much do you smoke a day?	
30. Do you drink alcohol? ☐ Beer ☐ Wine ☐ Liquor	☐ Yes ☐ No ☐ Some
How often do you drink?	
31. For women, are you pregnant or do you think you may be pregnant?	☐ Yes ☐ No ☐ Unsure
32. Are there any other problems about your health that you know of?	☐ Yes ☐ No ☐ Unsure
* If you answered "yes" for any of the above, please explain:	

Dental History

33. What are your major dental concerns?			
34. Date of last dental visit?		**35.** Date of last dental x-rays?	
36. Please check any statements which apply.			
☐ I have my teeth cleaned at least once a year.		☐ I brush my teeth twice a day.	
☐ I floss my teeth at least once a day.		☐ There is fluoride in my drinking water.	
☐ I use a toothpaste that contains fluoride.		☐ I also use or have used other forms of fluoride.	
☐ I am happy with the appearance of my teeth.		☐ My gums bleed when I brush, floss or eat.	
☐ Food or dental floss catches in between my teeth.		☐ Some of my teeth are becoming loose.	
☐ My teeth are sensitive to hot, cold, &/or pressure.		☐ Some of my teeth ache.	
☐ I experience pain &/or clicking in my jaw joints.		☐ There are sores or growths in my mouth.	
☐ I now have spaces between my teeth where there were no spaces previously.			
☐ I am worried about receiving dental treatment.			
37. Have you ever fainted during a dental visit?			☐ Yes ☐ No ☐ Unsure
38. Have you experienced an unusual reaction to dental medication or anesthetic?			☐ Yes ☐ No ☐ Unsure
39. Have you experienced prolonged bleeding following dental treatment?			☐ Yes ☐ No ☐ Unsure
40. Have you had any other complications following dental treatment?			☐ Yes ☐ No ☐ Unsure
41. Have you had any injury to your teeth, jaws, or face?			☐ Yes ☐ No ☐ Unsure
42. Do you have any other dental concerns or complaints?			☐ Yes ☐ No ☐ Unsure

* If you answered "yes" to any of the previous questions, please explain:	

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to Dr. Washington at the earliest possible time, & I agree to do so. I give permission for this office to obtain from my physicians &/or dentists any additional information regarding my medical history needed to provide me the best periodontal treatment possible.

*** Signature of person completing this form:** _____

*** Relationship to patient:** _____ **Date:** _____

Do Not Write Below This Line	
Summery of History & Notation of Significant Findings:	
Medical Hx. reviewed by: _____	Date: _____
Health History Updates	
Date:	Last Medical Exam:
Health Changes:	Medications:
Pt. Signature:	Reviewed by:
Date:	Last Medical Exam:
Health Changes:	Medications:
Pt. Signature:	Reviewed by:
Date:	Last Medical Exam:
Health Changes:	Medications:
Pt. Signature:	Reviewed by:
Date:	Last Medical Exam:
Health Changes:	Medications:
Pt. Signature:	Reviewed by:

IMPORTANT INFORMATION FOR OUR PATIENTS

APPOINTMENTS

Our appointments are scheduled to respect your time. We reserve a specific time for your care and we make every effort to see you at that appointed time. We appreciate your promptness and consideration of our time. If you do need to change an appointment, a ***48-hour business notice is required****.* For example; Thursdays are considered the "48 hour notice period" for any appointment scheduled on a Monday. After three (3) failed appointments (Includes "no-shows" and cancelled appointments without proper 48-hour notice) you will be dismissed from the practice.

MEDICAL HISTORY

For your convenience, we mail or email the necessary paperwork to you. Please fill out the medical history and bring it to our office on your first visit. If your paper work is not completed, ***please arrive thirty (30) minutes*** prior to your appointed time to complete the necessary forms.

PICTURE ID

New guidelines require that we verify identification of new patients. Please have a photo

ID available.

RADIOGRAPHS

A full mouth series of radiographs is necessary for our office to make an accurate evaluation. Please make every effort to bring these or have your general dentist forward us a copy. Most insurance companies will pay for a full mouth series every 3 to 5 years. If we do not have access to these we will take them and you will be responsible for payment.

PAYMENT OPTIONS

For your convenience, we accept Visa, MasterCard, Discover, American Express, personal checks as well as Care Credit, which has several payment options. **We do not offer in office payment plans.**

DENTAL INSURANCE

Please keep in mind your insurance is a contract between you, your employer, and your insurance company and we are NOT a party to that contract. We are happy to assist you in obtaining the maximum benefit from your dental insurance plan. Once your plan has been verified, we will accept assignment of payment from your insurance company. Most plans cover a portion of the dental fee, which means you will be responsible for your deductible and the portion we estimate your plan will cover. Payment of your portion is expected *at the time* you are in our office for dental care. Please have your insurance card available. **Failure of your insurance company to reimburse or respond within 30 days will result in us billing you directly for the unpaid balance. We do use the services of a collection agency after 60 days.**

I understand that I am responsible for any debt from services rendered.

Patient/ Guardian Signature **Date**

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Note: Patients with insurance please sign below for your file.

I hereby authorize the release of all information from my records to my insurance companies.

_____ _____
Patient or Guardian Date

I hereby authorize payment of all dental payments payable to me to go directly to my dental provider.

_____ _____
Patient or Guardian Date

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Acknowledgement of Receipt of Notice of Privacy Practices

This practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices".

_____
Name of Patient (Print)

_____
Signature of Patient Date of Signature

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Request for Confidential Communication of Your Protected Health Information

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist, or secretary that regularly answers your calls? Yes No N/A

May we leave **messages** on a voicemail at work? Yes No N/A

May we discuss your **appointments/treatment** with your spouse/partner? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your **appointments and/or treatment** with your parent(s) or guardian? Yes No N/A

If you are over 18, may we discuss your **appointments and/or treatment** with your children? Yes No N/A

You must inform us **in writing** if you wish to change the manner in which this office communicates to you.

Thank you.

cc: patient dental record