Scott Henricksen, DDS

701 N 182nd St. Suite 102, Shoreline, WA 98133
P 206-542-7600 | F 206-542-7727 | info@shoreline-dentist.com

Welcome and thank you for choosing us as your dental providers! Our intent is to earn the trust you have shown by choosing us as your dental office. Please help us by completing the following confidential form.

Patient Information

Date _____

Last Name _____ First Name _____ M.I. _____

□ Male □ Female By what name would you like us to call you? _____

Date of Birth _____ / _____ /_____ Marital Status □ S □ M □ D □ W

Street Address _____ Home Phone _____

City/State/ZIP _____ Cell Phone _____

Email _____ Work Phone _____

Employer _____ Occupation _____

Responsible Party **(If different from above)**

Name _____ Relationship to Patient _____

□ Male □ Female Date of Birth _____ / _____ /_____

Street Address _____ Home Phone _____

City/State/ZIP _____ Cell Phone _____

Email _____ Work Phone _____

Emergency Contact

Name _____ Relationship to the Patient _____

Phone Numbers H _____ C _____ W _____

How did you find out about our office?

_____

Request for Confidential Communication

As my dental care provider, I give permission for you to do the following:

	YES	NO
Contact me at home	□	□
Contact me via cell phone	□	□
Contact me at work	□	□
Contact me via e-mail	□	□
Leave messages on my home answering machine	□	□
Leave messages on my cell phone voicemail	□	□
Leave messages on my work voicemail/answering machine	□	□

Insurance

Subscriber's Name _____ Relationship to the Patient _____

Subscriber's Date of Birth ____ / ____ / _____ SS# / ID _____

Insurance Company _____ Phone Number _____

Employer _____ Group Number _____

Do you have a secondary insurance? □ Yes □ No If yes, Please complete the following:

Subscriber's Name _____ Relationship to the Patient _____

Subscriber's Date of Birth ____ / ____ / _____ SS# / ID _____

Insurance Company _____ Phone Number _____

Employer _____ Group Number _____

Dental History (if information is known)

Name of previous dentist _____ Phone number _____

When was your last exam and cleaning? _____ X-Rays? _____

Do you have any questions about dentistry and oral health that you never had adequately answered for you?

_____

_____

Our practice is built on providing care to satisfied patients. As said before, our intent is to earn the trust you have shown by choosing us as your dental providers. We hope to serve you in a manner that will bring you to enthusiastically recommend us to your family, friends, and others in your community. Thank you!

Medical History

It is very important to answer all questions truthfully and to the best of your knowledge so that we can best plan your dental care and avoid any unnecessary personal health risks. Please assist us by completing the following, and let us know if you do not understand any part of this form:

Name:				Today's Date:
How do you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor				What do you consider to be your most important health issues?
Birth date:	Age:	Height:	Weight:	Who is your personal physician? / Physician's telephone:

Have you ever had or been treated for any of the following diseases/conditions? **Please check Yes or No and circle all that apply**. Thank you.

Yes ☐ No ☐ **HEART**
- Congestive heart failure
- Congenital heart malformation
- Valve problems / murmur
- Chest pain / angina
- Heart attack / myocardial infarct
- Cardiac arrhythmia
- Pacemaker / defibrillator / VAD

Yes ☐ No ☐ **VASCULAR**
- High / Low blood pressure
- Fainting / dizzy spells
- Central venous catheter / PICC
- Stroke, TIA

Yes ☐ No ☐ **BLEEDING DISORDERS**
- Hemophilia
- Anticoagulants
- Bruise easily
- Low / high platelets
- Anemia
- Transfusions
- Sickle cell disease

Yes ☐ No ☐ **LUNGS**
- Asthma, Bronchitis, Emphysema
- Pulmonary fibrosis / scarring
- Chronic cough, short of breath
- Pneumonia, tuberculosis
- Obstructive Sleep Apnea

Yes ☐ No ☐ **LIVER**
- Hepatitis (A,B,C, Autoimmune)
- Jaundice
- Cirrhosis, alcoholism

Yes ☐ No ☐ **DIGESTIVE TRACT**
- Diet (special/ restricted)
- Ulcers / GI Bleeding
- Gastric Reflux / Heartburn
- Colitis, Crohns, IBS
- Constipation / diarrhea
- Esophagus disease

Yes ☐ No ☐ **KIDNEY**
- Hemodialysis
- Peritoneal dialysis
- Acute or chronic Renal failure
- Polycystic

Yes ☐ No ☐ **HORMONES**
- Thyroid problems
- Diabetes / Pancreas disease
- Pituitary / Adrenal
- Gender hormone issues

Yes ☐ No ☐ **MUSCLES/SKELETON**
- Osteoporosis
- Artificial joints (hip, knee, etc.)
- Multiple sclerosis
- Myasthenia Gravis
- Muscular Dystrophy
- Trauma
- Swollen ankles

Yes ☐ No ☐ **IMMUNOLOGIC**
- Lupus
- Other autoimmune disease
- Immunosuppressive therapy
- Use of prednisone or similar

Yes ☐ No ☐ **CANCER** (Type: _____)
- Radiation therapy
- Chemotherapy
- Surgery

Yes ☐ No ☐ **PSYCHIATRIC**
- Psychiatric / Psychologic care
- Nervous / anxious
- Depression
- Developmental delay / autism
- Behavior issues
- Learning disability
- Alzheimer's / Dementia

Yes ☐ No ☐ **NEUROLOGIC**
- Seizures / Epilepsy
- Parkinson's
- Cerebral palsy

Yes ☐ No ☐ **INFECTIOUS DISEASE**
- HIV+
- Sexually transmitted disease
- Other infectious disease

Yes ☐ No ☐ **HEAD**
- Sinus trouble / Hay fever
- Migraine headaches
- Cold sores/ fever blisters
- Vision / hearing impairment

Yes ☐ No ☐ **HABITS**
- Tobacco (cigarettes, cigars, snuff)
- Alcohol (social, heavy, alcoholism)
- Drug abuse (street / prescription)

Women: Some medications used in dentistry will cross the placenta and breast milk, and might affect the unborn fetus. Antibiotic use may reduce the effectiveness of birth control pills, and alternate methods are recommended if taking them.

Are you pregnant? ☐Yes, _____ Months ☐No ☐Possibly or Not sure

Do you use birth control pills or injection? ☐Yes ☐No

Are you breastfeeding? ☐Yes ☐No

Using hormone replacement therapy (HRT)? ☐Yes ☐No

Please describe any conditions not listed, or use this space to give details about any of your medical issues:

(OVER)

Please list all medications you are currently taking. Be sure to include over-the-counter and herbal products: (attach extra paper if necessary)

Name	Dose / How often	Reason for taking

Please list all operations you have had:

Please list any allergies and/or bad reactions you have had:

☐ **NO KNOWN ALLERGIES**

To what	What happens?	How severe?

Would you care to speak to the dentist privately about any health issues? ☐ ***Yes*** ☐ ***No***

I have read and understand the questions on the health history. I have answered them to the best of my ability.

Signature of patient:	Date:
Signature of Legal Guardian, if applicable:	Date:

Legal Guardian's relationship to patient:

Doctor's use:	VS: B/P P SpO_2
	Exercise Tolerance (if applicable):

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ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of the Statement of Privacy Practices for the office of Scott Henricksen, DDS, containing a more complete description of the uses and disclosures of my protected health information (PHI) 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 the right to review and receive a copy of such Statement of Privacy Practices. I understand that my dental provider has the right to change the Statement of Privacy Practices and that I may contact this office to obtain a current copy of the Statement 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.

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 (PHI) to the person(s) identified below.

- Spouse □ YES □ NO
- Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses) □ YES □ NO
- Any Member of my extended family: (I.e. Parents, Grandchildren) □ YES □ NO
- Other (indicate here): _____ □ YES □ NO

Patient Name (please print): _____

Patient Signature (if 18+ years of age): _____ **Date:** _____

Patient's Personal Representative (please print):_____

Personal Representative Signature: _____ **Phone:** _____

FOR OFFICE USE ONLY:
We were unable to obtain the patient's written acknowledgement of our Statement of Privacy Practices due to the following reason:

□ The patient refused to sign □ Communication barriers □ Emergency situation □ Other _____

DENTAL RECORDS RELEASE AUTHORIZATION FORM

I, _____, authorize _____
(Patient name) (Previous dentist/dental office)

to release copies of all information contained in my dental files. This may include, but will not be limited to, medical and dental history, radiographs, description of treatment rendered, diagnosis and prognosis, further treatment deemed necessary, and other notes and charting.

Patient signature: _____ **Date:** _____

Patient name: _____

Patient D.O.B.: _____

Please send to:
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