Gayle K. James, 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 _______________

Please circle the number where you prefer to be reached.

Name of Your Employer ___________________________ Occupation ____________________

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

Name of Insured Person ___________________________ Relationship to Patient ______________

Insured's Birth Date ______________ Social Security # _______________ ID# ______________

Name of Insurance Company _________________________ Coverage Started ______________

Address to send claims ____
Street City State Zip

Insurance Company Phone ____________________ Group/Policy # ____________________

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? ______________________________________

Revised
04/09/09

Gayle K. James, DDS

MEDICAL and DENTAL HISTORY

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 (novacain)?……………………..…… 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?………No / Yes……………..Right……………Left……………..Both
2. Clicking / Popping?….……...No / Yes……………..Right……………Left……………..Both
3. Grating sound?……………... No / Yes……………..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

(please also complete second page)

Gayle K. James, DDS **Medical/Dental History (page 2)**

Patient Name ___________________________________

Do you wish to use nitrous oxide for your treatment? ($49-hr, usually not covered by insurance) Yes ❍ No❍

Physician ___________________________________ Location/Phone ______________________________

Have you ever had any of the following diseases or medical problems? Please Circle Y(Yes) N(No)

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

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

♀ **For Women**: Are you pregnant? Yes ❍ No ❍ Are you nursing? Yes ❍ No ❍
Are you currently taking oral contraceptives? Yes ❍ No ❍

Do you take medications, vitamins, herbs, over-the-counter medicines ? ☐Yes ☐No Please list :

__________________________ __________________________ __________________________
__________________________ __________________________ __________________________

Are you allergic to any of the following ? Please circle Y (Yes) or N (No):

Y	N	Aspirin	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 drugs or supplements that you are allergic to:_______________________________

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.

I understand that the information I have given today is correct, to the best of my knowledge:

Sign____Date_______________

Rev. 4/09/09
mf

Statement of Privacy Practices

Gayle K. James, DDS 22232 – 17th Ave SE, Suite 208 Bothell, Washington (425) 485-4010

We, at Gayle K. James, DDS are dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices, but will always inform you of any changes that might affect 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. This includes issues relating to your treatment, payment, and our dental care operations. However, your personal, protected health information will never be otherwise given to anyone –even family members- without your written consent. 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 of your records is always protected. Our privacy policy and practices apply to all current and former patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard quality of dental care, implement payment activities, conduct normal dental 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 more of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, the information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. This includes issues in which we reasonably believe you may be a victim of abuse, neglect, domestic violence or other crimes. We are also obligated to provide information to law enforcement officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voice mail messages, answering machines and postcards.

Patient Rights

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 Human Services.

We thank you for being a patient at Gayle K. James, DDS. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Rev. 4/09/09
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Gayle K. James, DDS
22232 17th Ave SE, Suite 208
Bothell, Washington 98021
(425) 486-4010

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for the offices of Gayle K. James, DDS. The Notice 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's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Gayle K. James, DDS reserves the right to change the privacy practices that are described in The Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below, (includes telephone calls regarding appointments):

(please circle all that apply)

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
MY SPOUSE ONLY	YES	NO
OTHER *(please specify)*	YES	NO
MAY WE CALL YOU AT WORK ?	YES	NO

____
Name of Patient or Personal Representative

____
Signature of Patient or Personal Representative

____
Date

____
Description of Personal Rep.'s Authority

For Our Patients With Insurance

Assignment of Insurance Benefits:
I hereby authorize payment of dental insurance benefits otherwise payable to me directly to Gayle K. James, DDS. I agree to be responsible for all charges for dental services within 60 days of service and understand that a service charge may apply for balances remaining over sixty days.

____
Signed (subscriber/patient)

____
Date