MK PERIODONTICS AND IMPLANTS
MEDICAL HISTORY AND QUESTIONNAIRE

Patient Registration

Date: _____

Name:_____ Birthdate:_____ Social Security Number:_____

Address:_____ City_____ Zip_____
Gender: Male/Female Marital Status: Single/Sig Other/ Married/ Divorced/ Widowed
Employer:_____ Occupation:_____
Phone Numbers: Home:_____ Work:_____ Cell:_____
Email address:_____ Preferred method of confirmation:_____
Spouse/Partner _____ Birthdate_____ Social Security #_____
Employer:_____ Occupation:_____
Work Phone:_____ Cell Phone: _____ Email:_____

If patient is a minor, please complete the following:

Name of person responsible for this account:_____
Relationship to Patient: _____
Address _____ City_____ Zip_____
Birthdate:_____ Social Security #_____ Home Phone: _____
Employer_____ Occupation_____ Work Phone _____

General Information:

Patient's General Dentist :_____
Patients Orthodontist:_____ Phone_____
Other people involved in Care:_____
Patients Physician:_____ Phone:_____
Emergency Contact:_____ Phone: _____
Preferred Pharmacy: _____ Phone:_____

Insurance Information:

Primary Dental Coverage:
Insurance Company: _____
Claims Address:_____
Policy Holder:_____
Birthdate:_____ ID#_____
Employer_____ Group#_____

Secondary Dental Coverage:
Insurance Company: _____
Claims Address:_____
Policy Holder: _____
Birthdate:_____ ID#_____
Employer_____ Group#_____

Primary Medical Coverage
Insurance Company: _____
Claims Address:_____
Policy Holder:_____
Birthdate:_____
Employer_____
Group #_____
ID#_____

DENTAL HISTORY AND QUESTIONNAIRE

What is your estimation of your dental health? ◉ Excellent ○ Good ○ Fair ○ Poor

Is your mouth comfortable now? ◉ Yes ○ No

If no, please describe the discomfort or problem:

_____

_____

_____

Do you have any active dental disease in your mouth that you are aware of?
◉ Yes ○ No

How long have you been with your present general dentist? _____

How much dentistry has been performed on your mouth this year? _____

Do any members of your family presently have or have they had in the past: (please list relationship to you)

☐ Dentures_____

☐ Periodontal disease_____

Are you satisfied with the appearance of your teeth? ◉ Yes ○ No

What would the loss of your natural teeth mean to you?

_____

_____

What are your goals and expectations of periodontal therapy?

_____

_____

Have you ever had any serious trouble associated with a previous dental experience? Please specify:

_____

_____

Please list any other comments regarding your teeth, mouth, or dental history:_____

_____

_____

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Patient Name: _____ Date: _____

Do you have, or have you had, any of the following?

Please circle all that apply

I. Skin

Itching _____

Rash _____

Ulcers _____

Pigmentations_____

Lack or loss of body hair_____

II. Extremities

Varicose veins_____

Swollen, painful joints_____

Muscle weakness, pain_____

Bone deformity, fracture_____

Osteoporosis/Osteopenia (circle one)

Joint Replacements_____

Prosthetic joints_____

Type:_____

Premed required/type:_____

III. Eyes

Blurring vision_____

Double vision_____

Drooping of eyelid_____

Glaucoma_____

IV. Ear, Nose, Throat

Dry Mouth_____

Earache_____

Frequent nosebleeds_____

Sinusitis_____

Frequent sore throat_____

Hoarseness_____

V. Respiratory

Sleep Apnea_____

Do you use a CPAP machine?_____

COPD_____

Cough, blood in sputum_____

Emphysema, bronchitis_____

Wheezing, asthma_____

Tuberculosis _____

VI. Cardiac

Shortness of breath_____

Pain, pressure in chest_____

Swelling of ankles_____

Arrhythmia_____

High/low blood pressure_____

Cholesterol_____

Rheumatic or scarlet fever_____

Heart Murmur, attack_____

Prosthetic valves/pacemakers_____

VII. Gastointestinal

Difficulty swallowing_____

Abdominal pain, ulcers_____

Hepatitis, jaundice_____

Liver disease_____

GERD_____

VIII. Genitourinary

Difficulty, pain on urination_____

Blood in urine_____

Excessive urination_____

Kidney infections_____

Sexually transmitted diseases_____

IX. Endocrine

Thyroid Trouble_____

Weight change_____

Diabetes/Type_____

Result/Date most recent HbA1c:_____

Excessive thirst_____

X. Hematopoietic

Easy bruising, excessive bleeding_____

Persistent lymphadenopathy_____

G6PD deficiency_____

Anemia_____

HIV infection, AIDS_____

Leukemia, **problems with immune system**_____

Spleen problems_____

XI. Neurologic

History of Head or Facial Trauma_____

History of Stroke or TIA_____

Frequent headaches_____

Dizziness, fainting_____

Epilepsy_____

Neuritis, neuralgia_____

Tingling/Burning, numbness_____

Paralysis_____

XII. Psychiatric

Nervousness_____

Irritability_____

Depression, Anxiety_____

Nervous breakdown_____

XIII. Growth or Tumor

Radiotherapy/chemotherapy_____

MK PERIODONTICS AND IMPLANTS
MEDICAL HISTORY AND QUESTIONNAIRE

Do you smoke tobacco and/or consume other recreational drugs? Yes/No
Do you use smokeless tobacco? Yes/No
History of alcohol or drug abuse? Yes/No

Do you take or have you taken any of these medications?

- Etidronate (Didronel)
- Tiludronate(Skelid)
- Neridronate
- Alendronate (Fosamax)
- Ibandronate (Bondronat/Boniva)
- Risendronate (Actonel)
- Clodronate(Bonefos, Loron)
- Pamidronate (Aredia)
- Olpadronate
- Zolendronate (Zometa)

List all medications/supplements you take and for what:

_____
_____
_____
_____

List all medication that cause **allergic reactions and symptoms:**_____

_____

Are you an organ donor/recipient? **Yes/No**

Other disease not listed?_____

Have you ever been diagnosed with or tested positive for COVID 19? **Yes/No**

Have you received the COVID 19 Vaccine? **Yes/No**

_____

FOR WOMEN:

Pregnant/Due Date:_____ Nursing: **Yes/No**
Contraceptives/other hormones (circle one) **Yes/No**
Have you noted a change in your menstrual pattern? **Yes/No**
Menopausal/premenopausal? **Yes/No**

FOR MEN:

Do you have a history of prostate cancer/prostate enlargement? **Yes/No**
Do you take medications for erectile dysfunction? **Yes/No**

I certify that any and all questions I had about the inquiries above have been answered to my satisfaction. I was asked all of the questions on this form and I have answered these questions truthfully and completely. I will not hold my dentist, or any other member his/her staff, responsible for any errors or omissions that I may have made.

_____ _____
Date **Signature of Patient**

_____ _____
Date **Signature of guardian (where applicable)**

FINANCIAL RESPONSIBILITY

Many patients have a commonly held misconception that medical and dental benefit policies that their employers, or they have purchased individually, will pay for all of their treatment. THAT IS INCORRECT AND UNTRUE.

As a patient in our office, you will receive treatment that is specific to the problems that are noted during your examination. Your doctor will carefully review his/her findings with you and explain to you the treatment options (if any) that are available to you. In return, your financial responsibility for the treatment that you agree to will be to the doctors' office. We will be glad to assist you in obtaining reimbursement for part of these benefits from your medical and/or dental insurance.

Often insurance companies, upon the patients' request, will send benefit reimbursement directly to the doctors' office. Please understand that your benefits contract will always have an allowable benefit payment for each procedure performed and that all allowable benefit is determined by the limitations of the contract that your employer or you have personally purchased from the insurer and does not always equal the doctor's submitted fee. Your insurance plan will pay only a percentage of the allowable benefit your employer or you have bought as part of your plan with a co-payment portion then being assigned to you. You are responsible to your doctor for payment of your yearly deductible, if not already satisfied, the patient co-payment portion, and any remaining portion of your doctor's bill that is not covered by your insurance plan.

We will be happy to discuss with you financial arrangements for the payment of your bill, whether or not you have medical/dental insurance available to you. Please understand that third party payment is NOT a guarantee of benefits payment, even though you may feel that you have the coverage under your insurance policy(ies). Financial responsibility for all services received at this office is yours alone. We will gladly work with you to arrange payment for services provided, and these arrangements will be set up on an individual needs basis.

Thank you for your confidence in our office and our doctors. We look forward to providing you with exceptional care and courteous service.

I HAVE READ THE ABOVE FINANCIAL RESPONSIBILITY STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MK PERIODONTICS & IMPLANTS, DR. KARBAKHSCH AND/OR ASSOCIATES, FOR ALL CARE AND SERVICES PROVIDED TO ME.

Patient Name_____

Signature_____ Date_____

AUTHORIZATIONS

I authorize the release of my dental records from MK Periodontics and Implants, Dr. Karbakhsch and/or Associates, to individuals involved in my dental care. I further authorize the release of records from any individuals to Drs. Karbakhsch and/or Associates.

I authorize release of medical information to insurance companies needed for the processing of claims.

I authorize insurance payments to be made directly to MK Periodontics and Implants, Dr. Karbakhsch and/or Associates. I understand that, regardless of coverage, I am responsible for any unpaid balance on my account within 90 days from the date of service, and a **10% monthly fee will be assessed on any unpaid balance over 90 days.**

I authorize photos, slides, filming (including video patient testimonials), x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry. My identity will not be revealed to the general public, unless authorized by me.

I am aware that should I not provide **three business days'** notice to change an appointment, I may be charged a fee of **$250 per hour for a surgical appointment and $100 per hour for an exam or hygiene appointment.**

I am aware of the Health Insurance Portability and Accountability Act (HIPPA)and will be provided a copy upon my request.

Patient Name_____

Signature_____ Date_____

STATEMENT OF PRIVACY PRACTICES

MK Periodontics & Implants

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, text/email messages 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.

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 if I do not fill this section out, my protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

☐ **Spouse Only**

☐ **Any member of my immediate family (i.e., Spouse, Children, Siblings, etc.)**

☐ **Any member of my extended family (i.e.. Parents, Grandchildren)**

☐ **Other individual(s):** _____

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 MK Periodontics & Implants. 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.

MK Periodontics & Implants 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.

Patients Printed Name: _____

Patient's Signature: _____

Date: _____

Parent or Guardian Signature(if applicable:) _____

Date: _____

MK Periodontics & Implants

Consent for Treatment during the era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "coronavirus," at any time or in any place. Be assured that we continue to follow state and federal regulations as well as recommended universal personal protective equipment (PPE) and disinfection protocols to limit transmission of all diseases in our office.

Despite our careful attention to sterilization, disinfection and the use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be exposed at your gym, grocery store or favorite restaurant. Although we have taken measures to enable social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dental healthcare team members and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes_____ No_____

_____ _____

Patient/Parent's Signature Date