# M.CLARK BLANCHARD DDS PLLC

COSMETIC AND RESTORATIVE DENTISTRY
4301 FACTORIA BLVD SE, SUITE A
BELLEVUE WA 98006
**PH (425) 641-8600**
FX (425) 952-0362 **Today's Date**:_____

## PATIENT INFORMATION

**Name:**_____**Date of birth**:_____
(**Patient**) (first) (middle initial) (last)

**Whom may we thank for referring you?**_____

**Additional Family Member(s) Names(s)**
**(1)**_____**Date of birth:**_____
**(2)**_____**Date of birth:**_____
**(3)**_____**Date of birth:**_____

**Previous Dentist** _____**Phone #**_____

**Date of last visit** _____

**Appointment Date:** _____

## RESPONSIBLE PARTY/BILLING INFORMATION

**Name:**_____**Date of birth**:_____
(first) (middle initial) (last)
**Relationship to patient**_____

**Contact Phone #** _____ **Alt Phone #**_____

**E-mail**_____

**Address**_____

**City**_____**Zip**_____

**Primary Dental Insurance**
**Employee Name**_____

**Employee DOB**_____

**Employer Name**_____

**Dental Ins Co.** _____

**Member ID or SSN#** _____

**Group #**_____

**2nd Dental Insurance**
**Employee Name**_____

**Employee DOB**_____

**Employer Name**_____

**Dental Ins Co.** _____

**Member ID or SSN #** _____

**Group #**_____

# HEALTH HISTORY

**Patient Name:** _____ **DOB:** _____

**Health Conditions –** Please check all that apply

**Asthma / Allergy**
- ☐ Asthma
- ☐ Hay Fever
- ☐ Use Inhaler
- ☐ Allergies

**Allergic Reactions to**
- ☐ Latex
- ☐ Penicillin Allergy
- ☐ Aspirin, Acetaminophen Or Ibuprofen

**Allergic Reactions to**
- ☐ Erythromycin Allergy
- ☐ Dental Anesthetic
- ☐ Reaction to Metals
- ☐ Tetracycline Allergy

**Women**
- ☐ Reached Menopause
- ☐ Pregnant
- ☐ Nursing
- ☐ Oral Contraceptives
- ☐ Hormones

**Blood Problems**
- ☐ Blood Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Easy Bruising
- ☐ Hemophilia
- ☐ Anemia
- ☐ Excessive Bleeding
- ☐ Previous Blood Transfusion

**Heart Problems**
- ☐ Angina /Chest Pain
- ☐ Congenital Heart Defect
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Valve Problem
- ☐ Taking Heart Medication

**Heart Problems**
- ☐ Artificial Heart Valve
- ☐ Heart Surgery
- ☐ Pacemaker
- ☐ MitralValve Prolapse
- ☐ Stroke
- ☐ Shortness of Breath
- ☐ Rheumatic Fever

**Liver Disease**
- ☐ Hepatitis
- ☐ Liver Disorder
- ☐ Jaundice

**STD**
- ☐ Aids
- ☐ HIV
- ☐ Herpes
- ☐ Other STD

**Thyroid Disease**
- ☐ Thyroid Problems
- ☐ Hypothyroid
- ☐ Hyperthyroid

**Joint or Bone Problems**
- ☐ Artificial Joints
- ☐ Arthritis
- ☐ Rheumatism

**Miscellaneous Health Conditions**

- ☐ Acid Reflux
- ☐ Breathing Difficulty
- ☐ Cancer
- ☐ Colitis
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug/Alcohol Abuse
- ☐ Dry Mouth
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Frequent Headaches
- ☐ Frequent Mouth Sores
- ☐ Glaucoma
- ☐ Growths
- ☐ Hospitalized
- ☐ Kidney Problems
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Persistent Cough
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Shingles
- ☐ Sinus Problems

- ☐ Swollen Glands
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Tobacco Use
- ☐ Ulcers
- ☐ Other

**Medication you are taking**

_____
_____
_____
_____
_____
_____

**Other Health Notes**

**Patient Signature**_____ **DATE**:_____

# RECORDS RELEASE
# M.CLARK BLANCHARD DDS PLLC
## AUTHORIZATHON TO RELEASE HEALTHCARE INFORMATION

**I request and authorize**
**(FROM)**
Dental office / Dr:_____
Phone #_____Email:_____
**to release any x-rays and pertinent dental or healthcare records for each of the below named patients to the following dental office:**

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Dental office: M.CLARK BLANCHARD DDS PLLC_____
Phone # (425) 641-8600_____Email:__info@clarkblanchard.com_ ___
Address: 4301 FACTORIA BLVD. SE SUITE A_____
City: BELLEVUE _____State: WA_____Zip Code:_98006_____

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Patient's name: _____Date of birth:_____

Patient's name: _____Date of birth:_____

Patient's name: _____Date of birth:_____

Patient's name: _____Date of birth:_____

Patient's name: _____Date of birth:_____

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Patient Signature: _____Date:_____

Parent/Guardian Signature_____

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## ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
2. Obtain payment from third party payers for my health care services
3. Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice 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.

Patient Name: _____Date: _____

Signature: _____

Relationship to patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

_____

**FOR OFFICE USE ONLY:**

___ Patient refused to sign

___ Emergency situation

___ Communication barriers

___ Other