Patient Information Form

Account #_____

Patient:_____ Date of Birth:_____

Mailing Address:_____City:_____

State:_____Zip:_____Email:_____

Cell Phone:_____ Other Phone:_____(H/W)

SSN:_____ Employer:_____ Occupation:_____

Spouse:_____ Date of Birth:_____

SSN:_____ Phone:_____(C/H/W)

If Minor: Responsible Parent:_____ Date of Birth:_____

SSN:_____ Parent's Cell:_____

Dental Insurance Information

Primary Insurance:_____ Group #:_____

Subscriber Name:_____ Date of Birth:_____

SSN/ID#_____ Employer:_____

Secondary Insurance:_____ Group #:_____

Subscriber Name:_____ Date of Birth:_____

SSN/ID#_____ Employer:_____

Medical Contact Information

Family Dentist:_____Phone:_____

Referring Dentist:_____ Phone:_____

Physician:_____Phone:_____

Pharmacy:_____ Phone:_____

Emergency Contact:_____

Relationship:_____ Phone:_____

Notice of Privacy Practices Acknowledgement

We keep a record of the healthcare services we provide to you. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used.

My signature acknowledges that a copy of this office's Notice of Privacy Practices is available for my review.

Medical History

	Yes	No
1. Are you taking any medications? **Please list below**	☐	☐

Medication Name	Dose (mg, freq)	Reason

	Yes	No
2. Are you allergic to any medication? **Please list below**	☐	☐

Medication Name	Reaction

	Yes	No
3. Do you currently or have you ever had any of the following? **Please circle** Artificial heart valve, artificial joint, asthma, diabetes, epilepsy, heart trouble, hepatitis, high blood pressure, HIV positive, kidney trouble, nervous disorder, stroke	☐	☐
4. Have you ever had any other serious illness? _____	☐	☐
5. Female patients: Are you pregnant? Due date:_____	☐	☐

Notes (For Doctor and Staff use only)

_____

_____

_____

_____

_____

_____

Permission for Diagnosis and Treatment

I, the undersigned, being the patient, parent or guardian of the above minor patient, consent to the performing of whatever procedure may be determined necessary by the Doctor.

I authorize and request the administration of such diagnostic tests, drugs, and/or anesthetics as may be deemed advisable by the Doctor. I also understand that upon completion of root canal therapy in this office I will be referred to my dentist for a permanent restoration such as an amalgam or composite filling or a crown.

I understand the root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

Signature of Patient or Parent:_____ Date:_____

Last Updated (If you are a returning patient, please initial and date in one box after you have reviewed and updated the information that you previously provided.)

Opioid (Narcotic) Information

Your doctor may elect to prescribe opioids to help manage your dental and/or post-operative pain. Opioids, also known as narcotics, include pain medications with names such as Vicodin, Norco, Percocet, Tylenol #3, oxycodone, hydrocodone, codeine, and many others. Although your doctor will recommend non-narcotic pain management as your first choice option, opioids may still be indicated in some cases.

Opioids can be addictive and an overdose can be fatal. Based on these risks, new state regulations require that we provide you information and you provide us information to determine if we are permitted to prescribe narcotic pain medication during your care.

We have provide you with a copy of the Washington State Department of Health "Prescription Opioids for Acute Pain" publication. We require that you read it and ask us any questions.

If we write you a prescription, we require that you consult with the pharmacist for further counseling and evaluation regarding the risks of opioid medication and if a naloxone prescription is indicated based on your medical history and risk classification. If so we require you receive a naloxone prescription before you fill our prescription.

We do not prescribe narcotics outside of normal business hours.

Please circle YES or NO for the following questions:

YES / NO Are you younger than 25 years of age?

YES / NO Are you currently taking any opioid medications? If so, who prescribed it and how much are you taking?

_____

YES / NO Are you currently taking any of the following types of medications: Benzodiazepines, Barbiturate, Sedatives, Carisoprodol, or Sleeping Medications (Z drugs)? (Please circle)

YES / NO Do you have a history of substance abuse or are you currently receiving medication assisted treatment (MAT)?

YES / NO Are you pregnant?

Please note that if you have answered YES to any of these questions or have left any of these questions blank, we may be unable to prescribe opioids.

If we are unable to prescribe narcotics and you feel that additional prescription pain medication is required, you must contact your physician who is supervising your care. They may or may not elect to prescribe opioid pain medication. They may contact us if they have any questions.

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By signing below I certify that I have received the information listed above. I will follow all instructions regarding opioids given to me by the doctor and this practice, and will follow all relevant state and federal laws regarding this and other controlled substances. I further certify that all information that I have provided is true and accurate. I understand that if my information changes, I am required to notify the doctor and staff by amending this form. I further understand that, if I have already been prescribed opioids and my information changes, I am not to fill or take the prescribed opioids without first receiving clearance from my physician.

Signature of Patient or Parent:_____ Date:_____

Prescription Opioids for Acute Pain

OCTOBER 2018 | DOH Pub 631-077

Washington State Department of Health

2018 Opioid Prescribing Requirements

Between the years 1999 to 2016, over 200,000 people in the United States died from a prescription opioid related overdose (CDC, 2017). A Washington State law passed in 2017 requiring opioid prescribing rules be written in response to the statewide opioid crisis.

Washington State Opioid Related Statistics

739 deaths (2017)

1,618 overdose hospitalizations (2017)

14,389 opioid use disorder admissions (2015)

324,000 individuals 12+ years who misused opioids in the last year (2016)

Opioid medications can be addictive and anyone is at risk for developing an opioid use disorder. Keep yourself and others safe by limiting usage, disposing of all unused medications, and knowing how to recognize the signs of opioid use disorder.

What you need to know as a patient

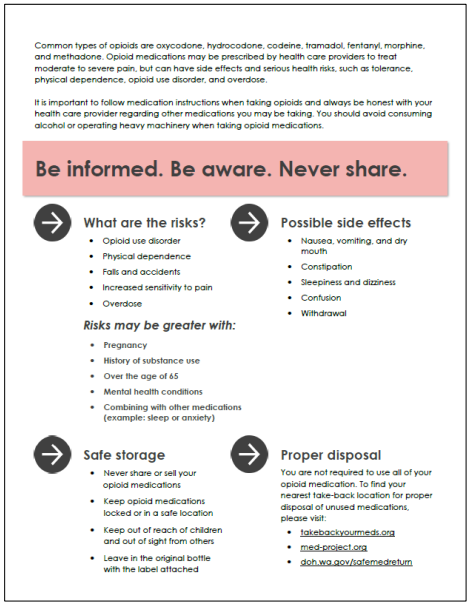
Prior to prescribing opioids, your health care provider may:

- Ask you to complete a risk assessment
- Ask more questions for your patient record
- Check the Prescription Monitoring Program to identify other medications or drugs of concern

Individual health care providers, practices, systems, pharmacies, and insurance companies may have more strict policies regarding opioids

Ask your health care provider questions about alternative treatment options for pain

Know your prescription, always follow instructions, and never take more than prescribed



Common types of opioids are oxycodone, hydrocodone, codeine, tramadol, fentanyl, morphine, and methadone. Opioid medications may be prescribed by health care providers to treat moderate to severe pain, but can have side effects and serious health risks, such as tolerance, physical dependence, opioid use disorder, and overdose.

It is important to follow medication instructions when taking opioids and always be honest with your health care provider regarding other medications you may be taking. You should avoid consuming alcohol or operating heavy machinery when taking opioid medications.

Be informed. Be aware. Never share.

What are the risks?

- Opioid use disorder
- Physical dependence
- Falls and accidents
- Increased sensitivity to pain
- Overdose

Risks may be greater with:

- Pregnancy
- History of substance use
- Over the age of 65
- Mental health conditions
- Combining with other medications (example: sleep or anxiety)

Possible side effects

- Nausea, vomiting, and dry mouth
- Constipation
- Sleepiness and dizziness
- Confusion
- Withdrawal

Safe storage

- Never share or sell your opioid medications
- Keep opioid medications locked or in a safe location
- Keep out of reach of children and out of sight from others
- Leave in the original bottle with the label attached

Proper disposal

You are not required to use all of your opioid medication. To find your nearest take-back location for proper disposal of unused medications, please visit:

- takebackyourmeds.org
- med-project.org
- doh.wa.gov/safemedreturn