

CONFIDENTIAL

PATIENT INFORMATION



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Seattle, WA 98103
(206) 784-4800

PATIENT # _____

DATE _____

(PLEASE PRINT)

NAME _____ BIRTHDATE _____ HOME PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

X
SIGNATURE OF PATIENT OR PARENT IF MINOR

SIGNATURE

PATIENT NAME _____	TODAY'S DATE _____
HOME ADDRESS _____	DATE OF BIRTH _____
_____	HOME PHONE _____
BUSINESS ADDRESS _____	BUSINESS PHONE _____
_____	SOC. SEC. NO. _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____	OFFICE PHONE _____	DATE OF LAST EXAM _____
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<p>1. ARE YOU UNDER MEDICAL TREATMENT NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____</p> <p>4. DO YOU USE TOBACCO? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. ARE YOU WEARING CONTACT LENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?</p> <table style="width: 100%;"> <tr> <td>YES</td><td>NO</td><td>YES</td><td>NO</td><td>YES</td><td>NO</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">LOCAL ANESTHETICS (EG. NOVOCAINE)</td> <td colspan="2">BARBITURATES</td> <td colspan="2">ASPIRIN</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">PENICILLIN OR OTHER ANTIBIOTICS</td> <td colspan="2">SEDATIVES</td> <td colspan="2">OTHER</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">SULFA DRUGS</td> <td colspan="2">IODINE</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td colspan="2"></td> </tr> </table> <p>8. WOMEN ONLY: YES NO</p> <p>A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>B) ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>C) ARE YOU TAKING BIRTH CONTROL PILLS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	YES	NO	YES	NO	YES	NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LOCAL ANESTHETICS (EG. NOVOCAINE)		BARBITURATES		ASPIRIN		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PENICILLIN OR OTHER ANTIBIOTICS		SEDATIVES		OTHER		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SULFA DRUGS		IODINE				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
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9. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

<p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> HIGH BLOOD PRESSURE</p> <p><input type="checkbox"/> <input type="checkbox"/> HEART ATTACK</p> <p><input type="checkbox"/> <input type="checkbox"/> RHEUMATIC FEVER</p> <p><input type="checkbox"/> <input type="checkbox"/> SWOLLEN ANKLES</p> <p><input type="checkbox"/> <input type="checkbox"/> FAINTING / SEIZURES</p> <p><input type="checkbox"/> <input type="checkbox"/> ASTHMA</p> <p><input type="checkbox"/> <input type="checkbox"/> LOW BLOOD PRESSURE</p> <p><input type="checkbox"/> <input type="checkbox"/> EPILEPSY / CONVULSIONS</p> <p><input type="checkbox"/> <input type="checkbox"/> LEUKEMIA</p> <p><input type="checkbox"/> <input type="checkbox"/> DIABETES</p> <p><input type="checkbox"/> <input type="checkbox"/> KIDNEY DISEASES</p> <p><input type="checkbox"/> <input type="checkbox"/> AIDS OR HIV INFECTION</p> <p><input type="checkbox"/> <input type="checkbox"/> THYROID PROBLEM</p>	<p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> HEART DISEASE</p> <p><input type="checkbox"/> <input type="checkbox"/> CARDIAC PACEMAKER</p> <p><input type="checkbox"/> <input type="checkbox"/> HEART MURMUR</p> <p><input type="checkbox"/> <input type="checkbox"/> ANGINA</p> <p><input type="checkbox"/> <input type="checkbox"/> FREQUENTLY TIRED</p> <p><input type="checkbox"/> <input type="checkbox"/> ANEMIA</p> <p><input type="checkbox"/> <input type="checkbox"/> EMPHYSEMA</p> <p><input type="checkbox"/> <input type="checkbox"/> CANCER</p> <p><input type="checkbox"/> <input type="checkbox"/> ARTHRITIS</p> <p><input type="checkbox"/> <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT</p> <p><input type="checkbox"/> <input type="checkbox"/> HEPATITIS / JAUNDICE</p> <p><input type="checkbox"/> <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE</p> <p><input type="checkbox"/> <input type="checkbox"/> STOMACH TROUBLES / ULCERS</p>	<p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> CHEST PAINS</p> <p><input type="checkbox"/> <input type="checkbox"/> EASILY WINDED</p> <p><input type="checkbox"/> <input type="checkbox"/> STROKE</p> <p><input type="checkbox"/> <input type="checkbox"/> HAY FEVER / ALLERGIES</p> <p><input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS</p> <p><input type="checkbox"/> <input type="checkbox"/> RADIATION THERAPY</p> <p><input type="checkbox"/> <input type="checkbox"/> GLAUCOMA</p> <p><input type="checkbox"/> <input type="checkbox"/> RECENT WEIGHT LOSS</p> <p><input type="checkbox"/> <input type="checkbox"/> LIVER DISEASE</p> <p><input type="checkbox"/> <input type="checkbox"/> HEART TROUBLE</p> <p><input type="checkbox"/> <input type="checkbox"/> RESPIRATORY PROBLEMS</p> <p><input type="checkbox"/> <input type="checkbox"/> OTHER _____</p>
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COMMENTS	
<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>SIGNATURE OF DENTIST _____</p> <p>DATE _____</p>

PATIENT DENTAL HISTORY

<p>1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?</p> <p style="margin-left: 20px;">A) CLICKING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="margin-left: 20px;">B) PAIN (JOINT, EAR, SIDE OF FACE)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="margin-left: 20px;">C) DIFFICULTY IN OPENING OR CLOSING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="margin-left: 20px;">D) DIFFICULTY IN CHEWING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8. DO YOU HAVE FREQUENT HEADACHES? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>9. DO YOU CLENCH OR GRIND YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>12. HAVE YOU HAD ANY ORTHODONTIC WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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SIGNATURE	<p>I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.</p> <p style="font-size: 2em; font-weight: bold; margin-left: 20px;">X</p> <p style="text-align: center;">PATIENT, PARENT OR GUARDIAN _____ DATE _____</p>
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