Bone or Joint Problems *check all that apply*

___Arthritis ___Osteoporosis ___Stiff, Swollen or Painful joints
___Rheumatism ___Joint Replacement TYPE: _____ YEAR:_____
___Have you ever taken Bisphosphonates (**bone building medications**)? ____no ____yes

Allergy Problems *check all that apply*

___Sinus Problems ___Asthma ___Hay fever ___Persistent Cough ___Frequent sore throat

Other Medical *check all that apply*

___Stroke	___Hypoglycemia	___Shingles	___Fainting Spells, Seizures or Epilepsy
___Diabetes , is it controlled? Y/N	___Leukemia	___Glaucoma	___Migraines or frequent headaches
___Tuberculosis when? _____	___Multiple Sclerosis	___Hemophilia	___Tonsillectomy or Throat Surgery
___Scarlet Fever	___Liver Disease	___Lung Disease/COPD	___Hepatitis Type____
___Emphysema	___Hyperthyroid	___HIV/AIDS	___Psychological Treatment
___Hypothyroid	___STD's	___Ulcers	___ Acid Reflux/GERD

Do you have any disease, condition, or medical problem not listed?

_____

_____

Have you been hospitalized or had surgery within the past 5 years? ___no ___yes
If yes, for what? _____

Do you use tobacco? ___no ___yes Type: smoke / chew / dip how often? _____
Do you have a history of alcohol or drug dependency? ___no ___yes Currently? ____no ____yes
Do you drink alcohol? ___no ___yes 2-3 hours before bed? ___no ___yes
Do you drink caffeinated beverages? ___no ____yes 2-3 hours before bed? ___no ___yes

Sleep Issues:

Do you snore? ____no ____yes severity? ____Heavy ____Moderate ____Light
Do you wake unrested after a normal night of sleep? ____no ____yes
Have you ever been told that you stop breathing, gasp or choke while you are sleeping? ____no ____yes
Do you Experience night time sweating? ____no ____yes'
Do you have to get up several times per night to urinate ____no ____yes
Do you need extra pillows at night to prop you up and help you breath? ___no ____yes
Do you need caffeine to stay awake? ____no ____yes
Do you have a family history of sleep disorders? ____no ____yes
Do you take a sedative to help you sleep? ____no _____yes Name/Dose: _____
Have you been told you need to use a CPAP? ____no ____yes
If so, Do you? ____no ____yes If yes, How often? _____
Sleep Physician/Lab: _____ City:_____ Year?_____

I authorize the staff of 'Simply Smiles to perform any necessary services during diagnosis and treatment. I also authorize the release of any information required to process insurance claims. I understand the above questions and guarantee that this form was completed correctly to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____
Signature **Date**

Please check one: ____Adult patient ___Parent or Guardian ___Spouse

Thank you for assisting us in providing you with excellent care.

For Doctor's Use:_____

_____

Office use only: Reviewed/DDS: _____ Date: _____ Entered in computer: _____ Date: _____

Health History

Name_____ Date of Birth:_____

DENTAL

Prior/Current Dentist: _____City/State:_____Phone:_____
Year/Date of Last Exam:_____ Date of last X-rays?: _____

Reason for seeking care at this time?: _____
_____

Previous Orthodontic Treatment? ____no ____yes Approx year? _____
Oral habits?: Finger/thumb habit? ___ Lip Biting? ____ Mouth Breathing? ____ Poor Lip Seal? ____
Do you ever have unexplained pain in the face, cheeks, ears, throat or temples? ____no ____yes
Have you ever had a serious injury to the head, face, mouth or jaw? ____no ____yes
If Yes, *How/When?* _____

Jaw Problems

___Surgery ____Clench or Grind ____Pain/Cramping ____Clicking/Popping
___ Jaw locks open ____Wear a Night Guard ____Jaw won't open wide

MEDICAL

Physician Name_____City:_____ Phone:_____
Year/Date of Last Exam:_____ Height: _____ Weight: _____

Has your Dentist or Physician recommended you to take antibiotics before dental visits?: ____no ____ yes
If Yes, Why? _____ Medication: _____

For women:
Are you pregnant? _____ Due date: _____ Nursing?: _____ Birth Control Medication?:_____

ALLERGIES: ___I have no known allergies
Are you allergic, or have you reacted adversely, to any of the following: *check all that apply*

___Antibiotic, type_____ ___Aspirin ___Codeine ___ Dental Anesthetics
___Iodine ___ Latex ___Metals ___Pain Medications
___Plastics/acrylic ___Sleeping Pills ___Sulfa Drugs ___ Sulfites

Please list ***All Other Allergies*** not listed and provide specifics on any checked above:
_____
_____

MEDICATIONS: ___I do not take ANY medications
List **ALL MEDICATIONS** (***Prescription/Over the Counter or Recreational***) you are taking and **WHY**:
_____
_____
_____

Heart Problems *check all that apply*

___Chest Pains ___Heart Attack ___Congenital Heart Defect ___Irregular heart beat
___Heart Disease ___Heart Surgery ___Congestive heart failure ___Heart Murmur
___Rheumatic fever ___Mitral Valve Prolapse ___High blood pressure ___Shortness of breath
___Pacemaker ___Artificial heart valve ___Low blood pressure

Blood Problems *check all that apply*

___Easy bruising ___Abnormal bleeding ___Anemia ___Blood Transfusion

Cancer/Tumor *check all that apply*

___Radiation treatment ___Chemotherapy ___Type of cancer _____ Year _____

Simply Smiles

1348 8th ST NE

Auburn, WA 98002

(253)939-6900

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received and understand the practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide a revised Notice of Privacy Practices upon request.

Signature:_____ Date:_____ Date of Birth_____

**Relationship to patient if signed by a personal representative of patient:

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.

Any member of my immediate family ____yes ____no

OR

Spouse only___yes ___no

Other(please specify)_____ ___yes ___no