

PATIENT INFORMATION

Seattle's Family Dentistry

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Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have questions don't hesitate to ask.

Patient Full Name: _____ Date of Birth: _____ Age: _____
 Home Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____
 Billing Address (If different): _____ City: _____ State: _____ Zip: _____
 Best Number to reach you: _____ Other Number: _____
 Email: _____ Best time to be reached (Circle one): Day Afternoon Evening
 How did you hear about us? (Referral): _____
 Driver's License #: _____ State: _____ SSN#: _____
 Occupation: _____ Employer: _____ Work#: _____
 Spouse's Name & Phone #: _____ Emergency Contact name & Phone #: _____
 Name of Physician: _____ Date of last visit to Physician: _____
 Name of Previous Dentist: _____ Date of last visit to Dentist: _____

DENTAL HISTORY

Please mark any that apply:	Yes	No	Please mark any that apply:	Yes	No
Are you apprehensive about dental Treatment?	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush? _____		
Have you had problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss? _____		
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw make noise that bothers you or others?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your jaw frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Do your jaws ever feel tired?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty chewing food?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw get stuck so you can't open freely?	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Does it hurt when you chew or open wide?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or pain in front of your ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have jaw pain or headaches when you wake up?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss?	<input type="checkbox"/>	<input type="checkbox"/>	Does jaw pain effect your regular routine?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender?	<input type="checkbox"/>	<input type="checkbox"/>	Do you take medications for pain management?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed slow healing sores in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have TMJ or TMD?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>	Are you unable to open your mouth as wide as you would like to?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain when you come in contact with:			Do you have pain in the face, cheeks, jaws, joint throat or temples?(Circle all that apply)	<input type="checkbox"/>	<input type="checkbox"/>
Hot food or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have an uncomfortable bite?	<input type="checkbox"/>	<input type="checkbox"/>
Cold food or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a blow to the jaw (trauma)?	<input type="checkbox"/>	<input type="checkbox"/>
Sours? _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you a gum chewer or pipe smoker?(circle answer)	<input type="checkbox"/>	<input type="checkbox"/>
Sweets? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you want complete dental care?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>			
Are you happy with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
If no, why? _____					

MEDICAL HISTORY

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

Heart Problems

- | | Yes | No |
|-------------------------|--------------------------|--------------------------|
| Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Pressure problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Valve problem | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking heart medication | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart Valve | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|--------------------------|--------------------------|
| Thirsty or dry mouth most of the time | <input type="checkbox"/> | <input type="checkbox"/> |
| Family History of Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, how often? _____ | | |
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, how often? _____ | | |
| Hepatitis, Jaundice or liver trouble (Circle) | <input type="checkbox"/> | <input type="checkbox"/> |
| Herpes or other STD _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV-Positive | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis or other respiratory disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| History of head injury | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy or other neurological disease | <input type="checkbox"/> | <input type="checkbox"/> |
| History of drug or alcohol abuse? | <input type="checkbox"/> | <input type="checkbox"/> |

Blood Problems

- | | | |
|------------------------------|--------------------------|--------------------------|
| Easy Bruising | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent Nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> |
| Abnormal Bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disease (Anemia) | <input type="checkbox"/> | <input type="checkbox"/> |
| Received a Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> |

Allergy Problems

- | | | |
|---------------------------|--------------------------|--------------------------|
| Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin Rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking allergy medication | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have any disease, condition or problem that we should know about? If so, please describe: _____

Intestinal Problems

- | | | |
|----------------------------|--------------------------|--------------------------|
| Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight gain or loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Special Diet | <input type="checkbox"/> | <input type="checkbox"/> |
| Constipation/Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney or bladder problems | <input type="checkbox"/> | <input type="checkbox"/> |

Bone or Joint Problems

- | | | |
|--|--------------------------|--------------------------|
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Back or neck pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint replacement | <input type="checkbox"/> | <input type="checkbox"/> |
| (Example total hip, pins or implants)(circle) | | |
| Fainting spells, Seizures or Epilepsy(Circle all that apply) | <input type="checkbox"/> | <input type="checkbox"/> |
| Strokes | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent or severe headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough or swollen glands | <input type="checkbox"/> | <input type="checkbox"/> |
| Premedication required by Physician | <input type="checkbox"/> | <input type="checkbox"/> |

MEDICAL HISTORY CONTINUED

Are you allergic, or have you reacted adversely, to any of the following?	Yes	No
Local Anesthetics ("Novocaine")	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

During the past 12 months, have you taken any of the following?	Yes	No
Antibiotics or sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (Example: Coumadin)	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure Medication	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis or drugs for heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (Steroids)	<input type="checkbox"/>	<input type="checkbox"/>
Natural Remedies	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug/supplements	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Women	Yes	No
Are you taking contraceptives or Other hormones? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms? _____		

By signing this form you certify that the information above is correct and filled out to the best of your knowledge.

Thank-You!

Patient/ Parent Signature

Date

Dentist Initials