Welcome to

Pacific Ave Dental

Allan L. Hablutzel, D.D.S. Family Dentistry

820 Pacific Ave., Suite 204, Bremerton, WA 98337

Patient Information

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 any questions, please don't hesitate to ask.

Patient name_____ Today's date_____

Date of Birth _____SSN_____ Gender_____

Driver's license number_____ State_____

Home address_____

Phone_____ Cell Phone_____ Email _____

Preferred method of communication? _____

Billing address *(if different from above)* _____

Employer/occupation_____Business phone_____

Spouse's name_____Spouse's phone_____

Emergency contact and phone *(other than spouse)* _____

Primary dental insurance_____ Group number_____

Subscriber's name_____Date of birth_____

Subscriber's insurance number_____ Age_____ Sex_____

Secondary dental insurance_____Group number_____

Secondary subscriber's name _____ Date of birth_____

Subscriber's insurance number_____ Age_____ Sex_____

Name of your medical doctor_____ Date of last visit _____

Name of previous dentist_____Date of last visit _____

Whom may we thank for referring you? _____

Dental health history

Do you have or have you had any of the following?(check all that apply)

☐ Apprehension about dental treatment
☐ Problems with previous dental treatment
☐ Gag easily
☐ Wear dentures
☐ Food catches between your teeth
☐ Difficulty chewing your food
☐ Chew on only one side of your mouth
☐ Avoid brushing any part of your mouth because of pain
☐ Gums bleed easily
☐ Gums bleed when flossing
☐ Gums feel swollen or tender
☐ Notice slow-healing sores in or around your mouth
☐ Feel twinges of pain with: ☐ Hot foods or liquids ☐ Cold foods or liquids ☐ Sour foods ☐ Sweet foods ?
☐ Take fluoride supplements
☐ Feel dissatisfied with the appearance of your teeth
☐ Want to save your teeth?
☐ Want complete dental care?
☐ Your jaw makes noise so that it bothers you
☐ Or others
☐ Clench or grind your teeth frequently
☐ Jaws feel tired
☐ Jaw gets stuck so that you can't open freely
☐ Pain when you chew or open wide to take a bite
☐ Earaches or pain in front of your ears
☐ Jaw symptoms or headaches upon awaking in the morning
☐ Jaw pain or discomfort affecting your appetite, sleep, daily routine, or other activities
☐ Jaw pain or discomfort that is extremely frustrating or depressing
☐ Take medications for pain or discomfort (pain relievers, muscle relaxants, antidepressants)
☐ Temporomandibular (jaw) disorder (TMD)
☐ Pain in the face, cheeks, jaws, joints, throat, or temples
☐ Unable to open your mouth as far as you want
☐ Aware of an uncomfortable bite
☐ Had a blow to the jaw or other facial trauma
☐ Habitually chew gum?
☐ Smoke? ☐ Pipe? ☐ Other? _____
☐ Use chewing tobacco?

How often do you brush? _____How often to you floss? _____

Medical health history

Do you have or have you had any of the following? (check all that apply)

☐Drink alcohol or use recreational drugs? If so, how much? _____?
☐Hepatitis, jaundice or liver trouble
☐Heart problems ☐Herpes or other STD
☐Chest pain ☐HIV positive/AIDS
☐Shortness of breath ☐Glaucoma
☐Blood pressure problem ☐Do you wear contact lenses?
☐Heart murmur ☐Head injury ☐Intestinal problems
☐Heart valve problem ☐Epilepsy or other neurologic disease
☐Taking heart medication ☐History of alcohol or drug abuse
☐Rheumatic fever ☐Asthma ☐Cancer
☐Pacemaker ☐Blood problems ☐Blood disease
☐Easy bruising ☐Frequent nosebleed/abnormal bleeding
☐Anemia ☐Artificial heart valve ☐Ever require a blood transfusion?
☐Allergy problems ☐Hay fever ☐Sinus problems
☐Ulcers ☐Weight gain or loss ☐Special diet
☐Constipation/diarrhea ☐Kidney or bladder problems
☐Arthritis ☐Fainting spells, seizures or epilepsy
☐Stroke(s) ☐Frequent or severe headaches
☐Back or neck pain ☐Bone or joint problems
☐Thyroid problems ☐Persistent cough or swollen glands
☐Tuberculosis or other respiratory disease
☐Joint replacement (e.g. hip, pins, implants) ☐Pre-medications required by physician?
☐Diabetes (type I or II?)_____ ☐Family history of diabetes
☐Urinate more than six times a day ☐Thirsty or mouth is dry much of the time
☐Other disease, condition or problem not listed above:
_____
_____

During the past 12 months, have you taken any of the following?

☐Antibiotics or sulfa drugs
☐Anticoagulants (e.g. Coumadin)
☐High blood pressure medicine
☐Tranquilizers
☐Insulin, Tolbutamide or similar drug
☐Aspirin
☐Digitalis or drugs for heart trouble
☐Nitroglycerin
☐Cortisone (steroids)
☐Natural remedies
☐Taking allergy medication ☐Nonprescription drug/supplements
☐Other: _____

Are you allergic or have you reacted adversely to any of the following?

☐Local anesthetics (Novocain)
☐Penicillin or other antibiotics
☐Sulfa drugs
☐Barbiturates, sedatives or sleeping pills
☐Aspirin, acetaminophen or ibuprofen
☐Codeine, Demerol or other narcotics
☐Metals
☐Latex or rubber dam
☐Other: _____
☐What medications are you currently taking?

_____
_____
_____

Women Only

☐Are you taking contraceptives or other hormones?
☐Are you pregnant?
☐If so, expected delivery date_____
☐Are you nursing?
☐Have you reached menopause?
☐If so, do you have symptoms?

Is there anything we can do or not do to make your dental visit more pleasurable?

_____
_____

Financial Policy

Payment is expected at the time of service. For your convenience we accept VISA, Mastercard, Discover, American Express, Cash, Checks, and Care Credit. If you have insurance we will estimate your insurance coverage with the information provided to us by your insurance company. As a courtesy, we will bill your dental insurance on your behalf. Any balances unpaid by insurance is the patient's responsibility to pay.

I have read, understand, and accept the terms of the above outlined policies for financial commitments that I (or the below named patient) may incur as a result of treatment at this office.

Patient signature _____ Date _____

Or legally authorized representative and relationship _____

Doctor signature _____Date _____