PATIENT INFORMATION

Seattle's Family Dentistry
10416 Aurora Ave. N
Seattle, WA 98133
Ph: (206) 466-2424

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**
Are you apprehensive about dental Treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty chewing food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you noticed slow healing sores in your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel pain when you come in contact with:		
Hot food or liquids? _____	☐	☐
Cold food or liquids? _____	☐	☐
Sours? _____	☐	☐
Sweets? _____	☐	☐
Do you take fluoride supplements?	☐	☐
Are you happy with the appearance of your teeth?	☐	☐
If no, why? _____		

Please mark any that apply:	**Yes**	**No**
How often do you brush? _____		
How often do you floss? _____		
Does your jaw make noise that bothers you or others?	☐	☐
Do you clench or grind your jaw frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so you can't open freely?	☐	☐
Does it hurt when you chew or open wide?	☐	☐
Do you have earaches or pain in front of your ears?	☐	☐
Do you have jaw pain or headaches when you wake up?	☐	☐
Does jaw pain effect your regular routine?	☐	☐
Do you take medications for pain management?	☐	☐
Do you have TMJ or TMD?	☐	☐
Are you unable to open your mouth as wide as You would like to?	☐	☐
Do you have pain in the face, cheeks, jaws, joint throat or temples?(Circle all that apply)	☐	☐
Do you have an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a gum chewer or pipe smoker?(circle answer)	☐	☐
Do you want complete dental care?	☐	☐

Continued on Back Side

Seattle's Family Dentistry
10416 Aurora Ave. N
Seattle, WA 98133
Ph: (206) 466-2424

MEDICAL HISTORY

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

	Yes	No
Heart Problems		
Chest Pain	☐	☐
Shortness of breath	☐	☐
Blood Pressure problems	☐	☐
Heart Murmur	☐	☐
Heart Valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic Fever	☐	☐
Pacemaker	☐	☐
Artificial heart Valve	☐	☐
Blood Problems		
Easy Bruising	☐	☐
Frequent Nosebleeds	☐	☐
Abnormal Bleeding	☐	☐
Blood disease (Anemia)	☐	☐
Received a Blood Transfusion	☐	☐
Allergy Problems		
Hay Fever	☐	☐
Sinus Problems	☐	☐
Skin Rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems		
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special Diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems		
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (Example total hip, pins or implants)(circle)	☐	☐
Fainting spells, Seizures or Epilepsy(Circle all that apply)	☐	☐
Strokes	☐	☐
Frequent or severe headaches	☐	☐
Thyroid Problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedication required by Physician	☐	☐

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

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

_____

_____

_____

Seattle's Family Dentistry
10416 Aurora Ave. N
Seattle, WA 98133
Ph: (206) 466-2424

MEDICAL HISTORY CONTINUED

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

Women	Yes	No
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 any symptoms? _____		
_____		

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

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