Patient Information and History (Confidential)

Patient Information (Please Fill Out Completely)

Name _____ SS# _____ Birthdate _____

Preferred Pronouns _____ Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____

Email _____ Check Appropriate Box: ☐ Minor ☐ Single ☐ Married

If Minor, Legal Guardian's Name _____ Patient's or Guardian's Employer _____

Work Phone _____

How did you hear about our office? ☐ Website ☐ Google Ad ☐ Facebook ☐ Yelp ☐ Insurance Provider

☐ Existing Patient _____ ☐ Other _____

Responsible Party (Please Fill Out Completely)

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information (Please Fill Out Completely)

Name of Subscriber _____ Relation to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Employer _____ Work Phone _____

Dental Insurance Company _____ Group # _____ ID # _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance Information (If Applicable)

Name of Subscriber _____ Relation to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Employer _____ Work Phone _____

Insurance Company _____ Group # _____ ID # _____

Address _____ City _____ State _____ Zip _____

Release

- I authorize the Dental Health Providers at 425 Dental to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
- I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental or medical care payor.
- I understand that I am financially responsible for payment in full of all accounts. Finance charges of 1% monthly will be applied to balances due over 90 days (per RCW 19.52)

Patient's or Responsible Party's Signature _____ Date _____

425 DENTAL

Dental/Medical History
(Confidential - Page 1)

Dental History

Reason for Today's Visit _____ Date of Last Dental Visit _____

Former Dentist _____ Date of Last Dental X-Rays _____

Address _____

Check if you have had any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food Collection Between Teeth
- ☐ Grinding Teeth
- ☐ Loose Teeth or Broken Fillings
- ☐ Past Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting
- ☐ Sores or Growths in Your Mouth

Are you apprehensive about dental treatment? _____

Are you dissatisfied with the appearance of your teeth? _____

Medical History

Physician's Name _____ Physician Contact _____ Date of last visit _____

Specialty Providers (e.g. Cardiologist) _____ Provider Contact _____

Date of last visit _____

Have you ever taken any of the group of drugs collectively called "bisphosphonates" (examples of common bisphosonates include Fosamax, Boniva, Actonel, etc.)? ☐ Yes ☐ No

Are you taking blood thinners? (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish Oil, etc.)? ☐ Yes ☐ No

Do you currently or have you had mental health problems/anxiety/depression? ☐ Yes ☐ No

Have you had any serious illness or operation? ☐ Yes ☐ No If yes, please describe _____

Have you had a blood transfusion? ☐ Yes ☐ No If yes, please give approximate date _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Have you been told by your medical provider that you need to take antibiotics before dental treatment? ☐ Yes ☐ No

Check if you have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cortisone Treatments
- ☐ Persistent Cough
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Veneral Disease

Please see reverse page.

Dental/Medical History
(Confidential - Page 2)

Medications

List Medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

Allergies

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other _____

Sleep/Snore History

Do you snore or have you been told you snore?	☐ Yes	☐ No
Are you ever tired during the day?	☐ Yes	☐ No
Have you been told you quit breathing during sleep or awaken suddenly in your sleep?	☐ Yes	☐ No
Do you ever wake up with headaches in the morning?	☐ Yes	☐ No
Have you been told to wear a CPAP device or do you wear a CPAP device?	☐ Yes	☐ No
Have you ever been asked to or have you taken a sleep study?	☐ Yes	☐ No
Do you take medication for high blood pressure?	☐ Yes	☐ No

Additional Information

Please indicate any additional areas you are interested in having the doctor discuss with you.

Orthodontics
- ☐ Invisalign
- ☐ Retainers

Cosmetic Dentistry
- ☐ Veneers
- ☐ Teeth Whitening

Specialty Care
- ☐ Wisdom Teeth Removal
- ☐ Root Canal
- ☐ Implants
- ☐ Gum Grafting
- ☐ Smile Makeover

Botox/Fillers
- ☐ Therapeutic (headaches, migraines, TMD)
- ☐ Cosmetic (wrinkles and fine lines)
- ☐ Grinding & Clenching
- ☐ Dermal Fillers

Additional Comments

Please write anything you would like to discuss with your provider or would like the team know about you:

_____

_____

_____

_____

_____

_____

_____

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold the Dental Health Providers at 425 Dental or their staff responsible for any errors or omissions that I may have made in completion of this form. I will inform the doctor if my health or medications change in any way.

Patient's or Responsible Party's Signature _____ Date _____