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Welcome to our office, so we may become acquainted, please provide the following information on the front and back of this form.

Today's date _____

PATIENT NAME _____ Gender _____ Age _____ Date of Birth ____/____/____
Parent/Guardian(if patient is a minor) _____
Address _____ City _____ State _____ Zip _____
How long at this address _____ Cell Phone(_____) _____
Home phone no.(_____) _____ Daytime phone(if different) no.(_____) _____
Occupation _____ Employer _____
Business Address _____ Business Phone(_____) _____
Date employed _____ Social Security Number _____
Email Address _____

RESPONSIBLE PARTY INFORMATION

Guarantor and/or Spouse Name _____ Age _____ Date of Birth ____/____/____
Address _____ City _____ State _____ Zip _____
How long at this address _____ Cell Phone(_____) _____
Home phone no.(_____) _____ Daytime phone (if different) no.(_____) _____
Occupation _____ Employer _____
Business Address _____ Business Phone(_____) _____
Date employed _____ Social Security Number _____
Spouse's Name _____ Business Phone(_____) _____

REFERRED BY: ☐ Phone Book ☐ Location ☐ Patient (Name) _____ ☐ Other _____

Nearest relative (not living with you) _____ Relationship _____ Phone(_____) _____
Person to contact for emergency _____ Phone(_____) _____

DENTAL INSURANCE INFORMATION

DO YOU HAVE MEDICAL COUPONS? _____

Primary Dental Insurance Co. _____ Group/Policy # _____
Address _____ Phone(_____) _____
Insured's name and employer _____ DOB ____/____/____ SS# _____
Secondary Dental Insurance Co. (if applicable) _____ Group/Policy # _____
Address _____ Phone(_____) _____
Insured's name and employer _____ DOB ____/____/____ SS# _____

CONSENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the above named patient. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made. I authorize my insurance benefits to be paid directly to the dental office. I also authorize the dental office or insurance company to release any information required for this claim. I understand that I am responsible for any fees not paid by insurance and that a credit report may be obtained if necessary. I also understand that a \$50 - \$100 fee will be charged for missed appointments, and that this charge is not covered by insurance or any other state program as per WAC 388-535-1265(ff) and WAC 388-535-1100(s). I understand that if I need to change an appointment time, a 24-hour notification is necessary to avoid this fee. It is also clear to me that no further appointments can be scheduled until this fee has been paid. Additional charges may be incurred in the case of multiple missed appointments.

Signature _____ Relation to Patient _____ Date _____
Patient, Parent or Guardian

PATIENT MEDICAL HISTORY:**CIRCLE**

1. Have you been under the care of a physician during the last two years? ☐YES ☐NO
If Yes, please describe condition: _____
Physicians name _____ Phone(____) _____
2. Have you taken any medicine or drugs during the past two years? ☐YES ☐NO
If Yes, please list: _____
3. Do you have any known allergies? ☐YES ☐NO
If Yes, please list: _____
4. Have you been hospitalized or had any surgery in the past 5 years ☐YES ☐NO
If Yes, please describe: _____
5. Have you lost or gained more than 10 pounds in the past year? ☐YES ☐NO
6. If female, are you now pregnant? Due date? _____ ☐YES ☐NO
Are you currently nursing? ☐YES ☐NO

7. If you have had any of the following conditions, circle "Yes", if not circle "No".

- | | | |
|---|--|--|
| ☐ Yes ☐ No Rheumatic Fever | ☐ Yes ☐ No Asthma | ☐ Yes ☐ No Anorexia/Bulimia |
| ☐ Yes ☐ No Mitral Valve Prolapse | ☐ Yes ☐ No Emphysema/Bronchitis | ☐ Yes ☐ No Alcohol Addiction |
| ☐ Yes ☐ No Heart Disease or Attack | ☐ Yes ☐ No Sinus Trouble | ☐ Yes ☐ No Drug Addiction |
| ☐ Yes ☐ No Heart Murmur | ☐ Yes ☐ No Allergies | ☐ Yes ☐ No Cancer/Tumors |
| ☐ Yes ☐ No High Blood Pressure | ☐ Yes ☐ No Prolonged Bleeding | ☐ Yes ☐ No Radiation Treatment |
| ☐ Yes ☐ No Congenital Heart Lesions | ☐ Yes ☐ No Diabetes | ☐ Yes ☐ No Chemotherapy |
| ☐ Yes ☐ No Artificial Heart Valves | ☐ Yes ☐ No Anemia | ☐ Yes ☐ No Dry Mouth |
| ☐ Yes ☐ No Heart Pacemaker | ☐ Yes ☐ No Kidney Trouble | ☐ Yes ☐ No Herpes |
| ☐ Yes ☐ No Heart Surgery | ☐ Yes ☐ No Ulcers | ☐ Yes ☐ No Hepatitis |
| ☐ Yes ☐ No Chest Pains | ☐ Yes ☐ No Osteoporosis/Bone Disease | ☐ Yes ☐ No AIDS/HIV |
| ☐ Yes ☐ No Stroke | ☐ Yes ☐ No Epilepsy/Seizures | ☐ Yes ☐ No Venereal Disease |
| ☐ Yes ☐ No Jaundice/Liver Disease | ☐ Yes ☐ No Arthritis | ☐ Yes ☐ No Dizzy/Fainting Spells |
| ☐ Yes ☐ No Tuberculosis | ☐ Yes ☐ No Artificial Joints | ☐ Yes ☐ No Psychiatric Treatment |
| | ☐ Yes ☐ No Thyroid Disorder | |

PATIENT DENTAL HISTORY

1. Do you clench or grind your teeth? If Yes, When? Day or Night ☐YES ☐NO
2. Have you had any serious trouble associated with any previous dental treatment? ☐YES ☐NO
If Yes, please list _____
3. Are you having any specific problems with your teeth, gums or mouth at this time? ☐YES ☐NO
If Yes please list _____
4. Are you happy with your smile? ☐YES ☐NO
5. Have you had any head, neck or jaw injuries? ☐YES ☐NO
6. Do you chew or smoke tobacco in any form? ☐YES ☐NO
7. Have you undergone any previous periodontal surgery or oral surgery? ☐YES ☐NO
If Yes, please list _____
8. Have you ever experienced any ill effects from dental anesthetics, antibiotics or any other drug? ☐YES ☐NO
If Yes, please list _____
9. Do you notice any popping, clicking or soreness in the jaw? ☐YES ☐NO
10. How long has it been since your last dental visit and what office? _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY REVIEW

- | | | | |
|------------------------|------------------------|-------------------------|-------------------------|
| 1. DATE/INITIALS _____ | 5. DATE/INITIALS _____ | 9. DATE/INITIALS _____ | 13. DATE/INITIALS _____ |
| 2. DATE/INITIALS _____ | 6. DATE/INITIALS _____ | 10. DATE/INITIALS _____ | 14. DATE/INITIALS _____ |
| 3. DATE/INITIALS _____ | 7. DATE/INITIALS _____ | 11. DATE/INITIALS _____ | 15. DATE/INITIALS _____ |
| 4. DATE/INITIALS _____ | 8. DATE/INITIALS _____ | 12. DATE/INITIALS _____ | 16. DATE/INITIALS _____ |