We would like to get to know you better!

Date: ___________________________

Name: ____ SS# ________________________ ◻ Male ◻Female ◻Non-binary

Address: _________________________________ City: ______________________ State: ________ Zip: ________________

Home Phone: _____________________ Work Phone: ______________________ Cell phone: _________________________

E-mail Address: ____ Date of Birth: ______________________

Occupation: _______________________________________ Employer: ____

Parent or Spouse's Name: ___________________________ Their Phone # ____

Who may we thank for referring you? ____

Person to Contact in case of emergency: __________________________________ Phone: ____________________________

Person responsible for dental investment: ____

For dependents 18 years and older that are covered under parent's insurance we will need their student status for insurance processing.

Student Status: Full Time Total Semester Hr's ___________________ Part Time Total Semester Hr's __________________

For Insurance Purposes:

Name of policy holder: ____________________________ Date of Birth: _________ Relationship to Patient: ____________

SS# ________________ Member I.D. _________________ Employer Insurance Company: ____________________________

Ins. Company: _____________________ Phone # ___________________ Group Number: ___________________________

••

HIPPA Compliance Statement

Your health information may be used in our office to conduct scheduling and coordination of care between the doctor, dental assistant, hygienist, business office staff, and other dental specialists that are involved in your care. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. Your health information may be reviewed during the routine process of certification, licensing, credentialing activities or auditing for quality assurance.

Communication with our patients in an important part of our philosophy. We prefer to communicate with you directly but we may incorporate the use of phone messages, postcards, and letters. We will make every effort to respect your privacy and honor your request for confidentiality. If you have special needs in regards to privacy issues, please put them in writing for the office so that we may address your concerns.

••

Patient Signature: ____ Date: ______________________

MEDICAL HISTORY

Patient Name: _____ Prefered Name: _____ Date of Birth: _____

Name of Physician/and their specialty _____

Most recent physical examination _____Purpose_____

What is your estimate of your general health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

DO YOU HAVE or HAVE YOU EVER HAD:	Y	N
1. hospitalization for illness or injury	[ ]	[ ]
2. an allergic or bad reaction to any of the following:		
○ aspirin, ibuprofen, acetaminophen, codeine	[ ]	[ ]
○ penicillin	[ ]	[ ]
○ erythromycin	[ ]	[ ]
○ tetracycline	[ ]	[ ]
○ sulfa	[ ]	[ ]
○ local anesthetic	[ ]	[ ]
○ fluoride	[ ]	[ ]
○ chlorhexidine (CHX)	[ ]	[ ]
○ metals (nickel, gold, silver, etc) _____	[ ]	[ ]
○ latex	[ ]	[ ]
○ nuts	[ ]	[ ]
○ fruit	[ ]	[ ]
○ other	[ ]	[ ]
3. heart problems, or cardiac stent within the last six months	[ ]	[ ]
4. history of infective endocarditis	[ ]	[ ]
5. artificial heart valve, repaired heart defect (PFO)	[ ]	[ ]
6. pacemaker or implantable defibrillator	[ ]	[ ]
7. orthopedic implant (joint replacement)	[ ]	[ ]
8. rheumatic or scarlet fever	[ ]	[ ]
9. high or low blood pressure	[ ]	[ ]
10. a stroke (taking blood thinners)	[ ]	[ ]
11. anemia or other blood disorder	[ ]	[ ]
12. prolonged bleeding due to a slight cut (INR > 3.5)	[ ]	[ ]
13. pneumonia, emphysema, shortness of breath, sarcoidosis	[ ]	[ ]
14. chronic ear infections, tuberculosis, measles, chicken pox	[ ]	[ ]
15. asthma	[ ]	[ ]
16. breathing or sleep problems (e.g., sleep apnea, snoring, sinus)	[ ]	[ ]
17. kidney disease	[ ]	[ ]
18. liver disease	[ ]	[ ]
19. jaundice	[ ]	[ ]
20. thyroid, parathyroid disease, or calcium deficiency	[ ]	[ ]
21. hormone deficiency	[ ]	[ ]
22. high cholesterol or taking statin drugs	[ ]	[ ]
23. diabetes (HbA1c =)	[ ]	[ ]
24. stomach or duodenal ulcer	[ ]	[ ]
25. digestive or eating disorders (e.g., celiac disease, gastric reflux,	[ ]	[ ]
26. osteoporosis/osteopenia (e.g., taking bisphosphonates)	[ ]	[ ]
27. arthritis	[ ]	[ ]
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)	[ ]	[ ]
29. glaucoma	[ ]	[ ]
30. contact lenses	[ ]	[ ]
31. head or neck injuries	[ ]	[ ]
32. epilepsy, convulsions (seizures)	[ ]	[ ]
33. neurologic disorders (ADD/ADHD, prion disease)	[ ]	[ ]
34. viral infections and cold sores	[ ]	[ ]
35. any lumps or swelling in the mouth	[ ]	[ ]
36. hives, skin rash, hay fever	[ ]	[ ]
37. STI/STD/HPV	[ ]	[ ]
38. hepatitis (type_____)	[ ]	[ ]
39. HIV/AIDS	[ ]	[ ]
40. tumor, abnormal growth	[ ]	[ ]
41. radiation therapy	[ ]	[ ]
42. chemotherapy, immunosuppressive medication	[ ]	[ ]
43. emotional difficulties	[ ]	[ ]
44. psychiatric treatment	[ ]	[ ]
45. antidepressant medication	[ ]	[ ]
46. alcohol/recreational drug use	[ ]	[ ]
ARE YOU:		
47. presently being treated for any other illness	[ ]	[ ]
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea)	[ ]	[ ]
49. taking medication for weight management	[ ]	[ ]
50. taking dietary supplements	[ ]	[ ]
51. often exhausted or fatigued	[ ]	[ ]
52. experiencing frequent headaches	[ ]	[ ]
53. a smoker, smoked previously or use smokeless tobacco	[ ]	[ ]
54. considered a touchy/sensitive person	[ ]	[ ]
55. often unhappy or depressed	[ ]	[ ]
56. taking birth control pills	[ ]	[ ]
57. currently pregnant	[ ]	[ ]
58. diagnosed with a prostate disorder	[ ]	[ ]

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature:_____ Date: _____

Doctor's Signature: _____ Date: _____

 www.koiscenter.com ASA _____(1-6)

DENTAL HISTORY

Name_____ Nickname_____ Age_____

Referred by_____How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____How long have you been a patient?_____Months/Years

Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____

Date of most recent treatment (other than a cleaning) _____/_____/_____

I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:		**Y**	**N**
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]_____	[ ]	[ ]
2.	Have you had an unfavorable dental experience?_____	[ ]	[ ]
3.	Have you ever had complications from past dental treatment?_____	[ ]	[ ]
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?_____	[ ]	[ ]
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?_____	[ ]	[ ]
6.	Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?_____	[ ]	[ ]
GUM AND BONE			
7.	Do your gums bleed or are they painful when brushing or flossing? _____	[ ]	[ ]
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	[ ]	[ ]
9.	Have you ever noticed an unpleasant taste or odor in your mouth? _ _____	[ ]	[ ]
10.	Is there anyone with a history of periodontal disease in your family? _____	[ ]	[ ]
11.	Have you ever experienced gum recession? _____	[ ]	[ ]
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? __	[ ]	[ ]
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	[ ]	[ ]
TOOTH STRUCTURE			
14.	Have you had any cavities within the past 3 years? _____	[ ]	[ ]
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	[ ]	[ ]
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	[ ]	[ ]
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____	[ ]	[ ]
18.	Do you have grooves or notches on your teeth near the gum line? _____	[ ]	[ ]
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	[ ]	[ ]
20.	Do you frequently get food caught between any teeth? _____	[ ]	[ ]
BITE AND JAW JOINT			
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	[ ]	[ ]
22.	Do you feel like your lower jaw is being pushed back when you bite your back teeth together?_____	[ ]	[ ]
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ___	[ ]	[ ]
24.	In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?_____	[ ]	[ ]
25.	Are your teeth becoming more crooked, crowded, or overlapped? _____	[ ]	[ ]
26.	Are your teeth developing spaces or becoming more loose? _____	[ ]	[ ]
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?_____	[ ]	[ ]
28.	Do you place your tongue between your teeth or close your teeth against your tongue?_____	[ ]	[ ]
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	[ ]	[ ]
30.	Do you clench or grind your teeth together in the daytime or make them sore?_____	[ ]	[ ]
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?_____	[ ]	[ ]
32.	Do you wear or have you ever worn a bite appliance? _____	[ ]	[ ]
SMILE CHARACTERISTICS			
33.	Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?_____	[ ]	[ ]
34.	Have you ever whitened (bleached) your teeth? _____	[ ]	[ ]
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	[ ]	[ ]
36.	Have you been disappointed with the appearance of previous dental work? _____	[ ]	[ ]

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

BELLEVUE OVERLAKE DENTAL

Your Smile for Life

Our Mission:

Welcome to our office! Whatever your dental needs, our team is here to provide outstanding care in a friendly, relaxed and professional environment. Our patients are our #1 priority and we are happy you found us!

Everything we do has a singular purpose and this is to serve our patients well. We realize a visit to the dentist can be stressful, so we do everything we can to make your visit comfortable and worry free.

Should an emergency occur when we are away from the office, please contact us at (206) 992-3309.

☐ Initials

Financial Policy: I understand that payments are required at time of service. I understand that methods of payment include: all major credit and debit cards, cash, check and long-term payment plans through CareCredit.

☐ Initials

Cancellation Policy: I understand that if I need to make changes to my scheduled appointments, 48 hours' notice is required. I understand that there will be a **$75 charge per hour** of appointment booked for not giving proper notice before rescheduling and cancelling my appointment.

☐ Initials

Photo Release: I hereby give permission to the doctors at Bellevue Overlake Dental to use my photographs, related to my care, for education purposes and/or the marketing of his dental practice.

Patient Name: _____ Date: _____