Welcome To Washington Family Dentistry LLC

Personal Information

Today's Date _____/_____/_____ Date of Birth _____/_____/_____

Patient Name_____

SS#/SIN _____-_____-_____ Wishes to be called_____

Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐

Address_____

City_____ State_____ ZIP Code _____

Employer_____Occupation_____

Home Phone _____-_____-_____ Work Phone _____-_____-_____ Ext_____

Cell Phone _____-_____-_____ Referred by_____

Responsible Party

Name_____

Relationship to Patient_____

SS#/SIN _____-_____-_____ Date of Birth _____/_____/_____

Address_____

City_____ State_____ ZIP Code _____

Employer_____Occupation_____

Home Phone _____-_____-_____ Work Phone _____-_____-_____ Ext_____

Cell Phone _____-_____-_____

In case of an emergency, whom should we contact? _____

Relationship _____ Work# _____ Home# _____

Primary Dental Insurance

Name of Insured_____ Relationship to Patient_____

Insured's Birth Date _____/_____/_____ SS#/SIN _____-_____-_____

Employer_____ Occupation_____

Insurance Co _____ Group #_____

Insurance Co Address_____

Secondary Dental Insurance

Name of Insured_____ Relationship to Patient_____

Insured's Birth Date _____/_____/_____ SS#/SIN _____-_____-_____

Employer_____ Occupation_____

Insurance Co _____ Group #_____

Insurance Co Address_____

Authorization and Release

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and record of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and /or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist of dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance of services provided that are not fully covered by my insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf of on behalf on my dependant(s) if any.

Signature of patient (parent or guardian if patient is a minor):

Signature_____ Date _____/_____/_____

Relationship to Patient_____

Medical & Dental History Form

Today's Date _____/_____/_____ Date of Birth _____/_____/_____

Patient Name_____

Reason for visit _____

When was your last dental visit? _____

How often do you brush your teeth? _____ How often do you floss? _____

What texture toothbrush do you use? Soft ☐ Medium ☐ Hard ☐

Do your gums bleed while brushing? YES ☐ NO ☐ Do your gums bleed when flossing? YES ☐ NO ☐

Do you feel pain to any of your teeth when brushing or flossing? YES ☐ NO ☐

Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? YES ☐ NO ☐

Have you noticed any loosening of your teeth? YES ☐ NO ☐

Does food tend to become caught between your teeth? YES ☐ NO ☐

Do you have any sores or lumps in or near your mouth? YES ☐ NO ☐

Have you ever experienced any of the following problems in your jaw?

Clicking YES ☐ NO ☐ Pain (joint, ear, side of face) YES ☐ NO ☐

Difficulty in opening or closing? YES ☐ NO ☐ Difficulty chewing? YES ☐ NO ☐

Have you had any head, neck, or jaw injuries? YES ☐ NO ☐

Do you get frequent headaches? YES ☐ NO ☐ Do you bite your lips or cheeks frequently? YES ☐ NO ☐

Have you ever had?

Orthodontic treatment? YES ☐ NO ☐ Oral surgery? YES ☐ NO ☐

Gum treatment? YES ☐ NO ☐ Your teeth ground or the bite adjusted? YES ☐ NO ☐

Is there anything about having dental treatment that bothers you? YES ☐ NO ☐

Are you in good health? YES ☐ NO ☐

Have there been any changes in you general health within the past year? YES ☐ NO ☐

Date of your last physical exam: _____

Are you under the care of a Physician? YES ☐ NO ☐

Physician's name and phone number: _____

Have you ever been hospitalized for any surgical operation or serious illness? YES ☐ NO ☐

Please explain._____

Are you taking any medicine(s) including non-prescription medicine? YES ☐ NO ☐

If yes, what are you taking? _____

_____

Have you ever taken Fen-Phen/Redux? YES ☐ NO ☐ Have you had a recent weight loss? YES ☐ NO ☐

Have you had any abnormal bleeding? YES ☐ NO ☐ Are you wearing contact lenses? YES ☐ NO ☐

Have you ever had a blood transfusion? YES ☐ NO ☐ Do you bruise easily? YES ☐ NO ☐

Do you use alcohol? YES ☐ NO ☐ Do you use cocaine or other drugs? YES ☐ NO ☐

Do you use tobacco? YES ☐ NO ☐

Do you have any disease, condition or problem not listed above that we should know about? YES ☐ NO ☐

Do you have a persistent cough/throat clearing not associated with a known illness (lasting more than 3 weeks)?

YES ☐ NO ☐

Are you allergic to or have had any reactions to:

Local anesthetics like Novocain?	YES ☐ NO ☐	Sulfa Drugs?	YES ☐ NO ☐
Barbiturates, sedatives or sleeping pills?	YES ☐ NO ☐	Aspirin?	YES ☐ NO ☐
Penicillin/Amoxicillin	YES ☐ NO ☐	Iodine?	YES ☐ NO ☐

Other?_____

Do you have or have you ever had any of the following:

Heart trouble, heart attack or angina? YES ☐ NO ☐

- Do you have pain in your chest upon exertion? YES ☐ NO ☐
- Are you ever short of breath after mild exercise? YES ☐ NO ☐
- Do your ankles swell? YES ☐ NO ☐
- Do you get short of breath when you lie down? YES ☐ NO ☐
- Do you require extra pillows when you sleep? YES ☐ NO ☐

Pacemaker?	YES ☐ NO ☐	AIDS or HIV infection?	YES ☐ NO ☐
Heart surgery?	YES ☐ NO ☐	Thyroid Problems?	YES ☐ NO ☐
High blood pressure?	YES ☐ NO ☐	Allergies?	YES ☐ NO ☐
Low blood pressure?	YES ☐ NO ☐	Arthritis or rheumatism?	YES ☐ NO ☐
Hepatitis, Jaundice or liver disease?	YES ☐ NO ☐	Joint replacement or implant?	YES ☐ NO ☐
Stroke?	YES ☐ NO ☐	Stomach ulcer?	YES ☐ NO ☐
Sinus trouble?	YES ☐ NO ☐	Kidney trouble?	YES ☐ NO ☐
Lung or breathing problems?	YES ☐ NO ☐	Tuberculosis?	YES ☐ NO ☐
Asthma or hay fever?	YES ☐ NO ☐	Persistent cough?	YES ☐ NO ☐
Hives or skin rash?	YES ☐ NO ☐	Cough that produces blood?	YES ☐ NO ☐
Fainting spells or seizures?	YES ☐ NO ☐	Cancer?	YES ☐ NO ☐
Diabetes?	YES ☐ NO ☐	Sexually transmitted disease?	YES ☐ NO ☐
Epilepsy?	YES ☐ NO ☐	Anemia?	YES ☐ NO ☐
Glaucoma?	YES ☐ NO ☐	Leukemia?	YES ☐ NO ☐

Women only:

Are you pregnant or think you may be pregnant? YES ☐ NO ☐

Are you taking birth control pills? YES ☐ NO ☐ Are you nursing? YES ☐ NO ☐

If you answered yes to any of the previous questions, please explain:

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature_____ Date _____/_____/_____