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Email: info@pikeplacedental.com

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Please answer all questions on **all** pages, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

PATIENT'S NAME ______________________________ Nickname ______________

❑ Male ❑ Female Social Security No. ____________________ Birthdate ____/____/____

Mailing Address ______________________________ Home Phone ______________

City ______________________ State ____________ Zip Code ______________

Cell __________ Email __________ ❑ Married ❑ Single ❑ Partnered ❑ Other

Whom may we thank for referring you? ______________________________

Full-Time Student? School name & location ______________________________

Patient Occupation ____________ Employer ____________ Work Phone ____________

Name of Spouse ____________ Birthdate ____/____/____ Social Security No. ____________

Spouse Occupation ____________ Employer ____________ Work Phone ____________

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Employee ______________________	Employee ______________________
Employer ______________________	Employer ______________________
Insurance Co. ____________ Group # ________	Insurance Co. ____________ Group # ________
Employee's S.S. No. ______________	Employee's S.S. No. ______________

Person responsible for payment: ______________________________

* * * * * *

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name ______________________ Home Ph. No. ____________ Work Ph. No. ____________

Relationship to Patient ______________________________

PIKE PLACE DENTAL

Kent deVigné, D.D.S., M.P.H.

DENTAL HISTORY

Chief dental concern: ______________________

Are you nervous about having dental treatment? ❑ Yes ❑ No

Have you ever had a bad dental experience? ❑ Yes ❑ No

Have you ever been premedicated to reduce dental anxiety? ❑ Yes ❑ No

Do you have difficulty/pain when opening? ❑ Yes ❑ No

Do you grind/clinch your teeth at night/day? ❑ Yes ❑ No

Does your jaw get stuck, locked or "go out"? ❑ Yes ❑ No

Difficulty / pain when chewing, talking, or using your jaws/teeth? ❑ Yes ❑ No

Do you hear noises in your jaw joints? ❑ Yes ❑ No

Pain about the ears, temples, cheeks or jaw joint? ❑ Yes ❑ No

Does your bite feel uncomfortable or unusual? ❑ Yes ❑ No

Have you had a recent injury to your head / jaw? ❑ Yes ❑ No

Have you been treated for a jaw joint problem? ❑ Yes ❑ No

Do your teeth ever feel loose? ❑ Yes ❑ No

Does food catch in-between your teeth? ❑ Yes ❑ No

How often do you brush? ______ Floss? ______ ❑ Yes ❑ No

Any difficulty chewing your food? ❑ Yes ❑ No

Have you ever had periodontal/gum disease? ❑ Yes ❑ No

Do feel you have bad breath? ❑ Yes ❑ No

Are your teeth sensitive to cold / heat / etc? ❑ Yes ❑ No

Have you ever taken anitbiotics before dental care? ❑ Yes ❑ No

Do you have frequent Headaches? ❑ Yes ❑ No

Have you had Orthdontic care (braces)? ❑ Yes ❑ No

Do your gums bleed when you brush? ❑ Yes ❑ No

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? ______________________

____

HEALTH HISTORY

Do you feel you are in good health? ❑ Yes ❑ No

Are you having any pain or discomfort at this time? ❑ Yes ❑ No

Do you smoke or use tobacco in any form? ❑ Yes ❑ No

If yes, are you interested in support for smoking cessation? ❑ Yes ❑ No

Have you been hospitalized in the past 2 years? ❑ Yes ❑ No

Have you been under the care of a medical doctor during the past 2 years? ❑ Yes ❑ No

If yes, for what condition? ______________________

Physician Name ______________________

Address ______________________ Phone: ____________

Are you currently taking any medications /drugs? ❑ Yes ❑ No

List Medications: ______________________

____

Women: Are you pregnant? ❑ Yes ❑ No

Please list any serious medical condition(s) that you have/had:

____

____

Please check "Yes or No" to the following conditions:

Y N
- ❑❑ Angina Pectoris
- ❑❑ Heart Disease / Attack / Stroke
- ❑❑ Mitral Valve Prolapse
- ❑❑ Heart Failure
- ❑❑ High / Low Blood Pressure
- ❑❑ Congenital Heart Defect
- ❑❑ Heart Murmur / Rheumatic Fever
- ❑❑ Heart Surgery
- ❑❑ Heart Pacemaker
- ❑❑ Artificial Heart Valve
- ❑❑ Diabetes Type: ________

Y N
- ❑❑ Blood Transfusion / Anemia
- ❑❑ Sickle Cell Disease
- ❑❑ Bruise Easily/Prolonged Bleeding
- ❑❑ Hemophilia
- ❑❑ Liver Disease / Yellow Jaundice
- ❑❑ Kidney Failure/Disfunction
- ❑❑ Thyroid Disease
- ❑❑ Ulcers
- ❑❑ Glaucoma
- ❑❑ Chemotherapy / Cancer
- ❑❑ X-ray / Cobalt Treatment

Y N
- ❑❑ Cosmetic Surgery
- ❑❑ Emphysema / Asthma
- ❑❑ Cough / Tuberculosis (TB)
- ❑❑ MRSA
- ❑❑ Osteporosis
- ❑❑ Arthritis / Rheumatism
- ❑❑ Cortisone Medicine
- ❑❑ Venereal Disease
- ❑❑ A.I.D.S. / H.I.V.
- ❑❑ Hepatitis: A B C **(circle one)**
- ❑❑ Frequent Headaches

Y N
- ❑❑ Artificial Joints (Hip, Knee)
- ❑❑ Scarlet Fever
- ❑❑ Fever Blisters / Cold Sores
- ❑❑ Fainting / Dizzy Spells
- ❑❑ Epilepsy / Seizures
- ❑❑ Hay Fever / Sinus Trouble
- ❑❑ Allergies / Hives
- ❑❑ Shingles
- ❑❑ Nervousness
- ❑❑ Psychiatric Treatment
- ❑❑ Depression/Bipolar **(circle one)**
- ❑❑ Drug / Alcohol Addiction

Are you allergic to or have you reacted adversely to the following?

❑ Antibiotics ❑ Aspirin ❑ Metals / Jewelry

❑ Codeine ❑ Latex ❑ Local/Dental Anesthetic

Are you aware of being allergic to any other medications or substances? If yes, please list:

____

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature ______________________ **Date** ____________

Medical History Update

(For Office Use Only)

Date ________ Comments ______________________ Date ________ Comments ______________________

Date ________ Comments ______________________ Date ________ Comments ______________________

Date ________ Comments ______________________ Date ________ Comments ______________________