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Liberty Lake, WA 99019



(509) 893-1119
www.LibertyLakeDental.com

Thank you for choosing our office. In order to serve you properly, please answer all questions on BOTH sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential.

PATIENT'S NAME _____ PREFERRED NAME _____

Male Female Social Security No. _____ - _____ - _____ Birthdate ____/____/____

Mailing Address _____ Email _____

City _____ State _____ Zip Code _____ Home Phone No. (____) _____

Cell Phone No. (____) _____ How should we contact you? Home Cell Work Email

Married Single Divorced Separated Widowed

Patient Occupation _____ Employer _____ Work Phone (____) _____

Name of Spouse _____ Birthdate ____/____/____ SSN _____

Spouse Occupation _____ Employer _____ Work Phone (____) _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (Other than someone living with you)

Name _____ Home Ph. No. (____) _____ Work Ph. No. (____) _____

Relationship to patient _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

Payment Is Expected At Time Of Each Visit

Please Check Method of Payment

Cash Check Bankcard Insurance

Person responsible for payment: _____

Primary Dental Insurance

Employee _____

Relationship to Patient _____

Employer _____

Insurance Co. _____ Group# _____

Insurance Phone No. _____

Employee's SSN _____

Subscriber D.O.B. _____

Secondary Dental Insurance

Employee _____

Relationship to Patient _____

Employer _____

Insurance Co. _____ Group# _____

Insurance Phone No. _____

Employee's SSN _____

Subscriber D.O.B. _____

I have been given and understand the Simonds Dental Group HIPPA Notices of Privacy Act.

Signature _____ Date _____

Dental History

<p>Are you having any pain or discomfort at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you nervous about having dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever had a bad dental experience? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you experience difficulty / pain when chewing, talking or using your jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have noises in your jaw joint? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does your bite feel uncomfortable or unusual? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever had an injury to your head or jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you been treated for a jaw joint problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chief dental concern: _____</p> <p>_____</p>	<p>Do you have dry mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do your teeth ever feel loose? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does food often catch in-between your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do your gums bleed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever had periodontal (gum) disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are your teeth sensitive to cold/heat/sweets? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you take antibiotics for a health condition before each dental visit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Previous Dentist's Name and Location: _____</p> <p>_____</p> <p>Are you happy with the way your smile looks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If not, what would you change? _____</p> <p>_____</p>
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Health History

<p>Do you smoke or use chewing tobacco (please circle one) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you been hospitalized or seen a Medical Doctor in the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If so, for what condition?</i> _____</p> <p>WOMEN: Are you pregnant or nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have a personal Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Physician's Name:</i> _____</p> <p><i>Date of last visit:</i> _____</p> <p><i>Reason for visit:</i> _____</p>	<p>Are you currently taking any prescriptions, over the counter drugs or herbal supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If so, please list and include the reason for taking:</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Have you ever taken Phen/fen, Redux or other diet related drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please list any serious medical condition(s) that you currently have or have had in the past: _____</p> <p>_____</p> <p>_____</p>
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Please Check any of the following which you have now or have had in the past.

<input type="checkbox"/> No medical conditions <input type="checkbox"/> Angina Pectoris (Chest Pain) <input type="checkbox"/> Heart Disease/Attack/Stroke <input type="checkbox"/> Heart Failure <input type="checkbox"/> High/Low Blood Pressure <input type="checkbox"/> Congenital Heart Defect <input type="checkbox"/> Heart murmur/Rheumatic Fever <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Heart Pacemaker <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Diabetes, Type I <input type="checkbox"/> II <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion/Anemia <input type="checkbox"/> High Cholesterol Disease <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Hemophilia/Blood Disorder/Sickle Cell	<input type="checkbox"/> Liver Disease/Yellow Jaundice <input type="checkbox"/> Kidney Failure/Dysfunction <input type="checkbox"/> Thyroid Disease/Condition <input type="checkbox"/> Ulcers <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cosmetic surgery _____ <input type="checkbox"/> Chemotherapy for Cancer <input type="checkbox"/> X-ray Treatment for Cancer <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Arthritis/Rheumatism/Lupus <input type="checkbox"/> Cortisone Medicine/Steroids <input type="checkbox"/> Venereal Disease/STDs <input type="checkbox"/> A.I.D.S./H.I.V. <input type="checkbox"/> Hepatitis: A, B, C <input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Artificial Joints (Hip, Knee, etc.) <input type="checkbox"/> Canker Sores/Cold Sores <input type="checkbox"/> Fainting/Dizzy Spells <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Hay Fever/Sinus Trouble <input type="checkbox"/> Allergies/Hives <input type="checkbox"/> Shingles <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Psychiatric Treatment <input type="checkbox"/> Drug/Alcohol Addiction <input type="checkbox"/> Emphysema/Asthma <input type="checkbox"/> Depressed Immune System <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other _____
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Are you allergic to or have you reacted adversely to any of the following?

Please check any that apply.

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Demerol	<input type="checkbox"/> Valium	<input type="checkbox"/> Nitrous Oxide	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Other Antibiotics	<input type="checkbox"/> Metals/Jewelry
<input type="checkbox"/> Codeine	<input type="checkbox"/> Percodan	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Latex	<input type="checkbox"/> Local Anesthetic

List any other allergies here: _____

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. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover.

Patient Signature _____ **Date** _____

Doctor Signature _____ **Date** _____

Update Record	
Date	Initial
_____	_____
_____	_____