

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 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:

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to _____			27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen			28. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			29. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> codeine			32. neurologic problems _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			33. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (gold, stainless steel)			35. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> any other medications _____			37. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems _____	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7. high blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8. low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. a stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. artificial prosthesis (i.e. heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol / drug dependency _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>			
12. prolonged bleeding due to a slight cut _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
13. emphysema _____	<input type="checkbox"/>	<input type="checkbox"/>	46. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47. aware of a change in your general health _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	48. taking medication for weight management (i.e. fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51. subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	52. a smoker or smoked previously _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid or parathyroid disease _____	<input type="checkbox"/>	<input type="checkbox"/>	53. considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol _____	<input type="checkbox"/>	<input type="checkbox"/>	55. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	56. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	57. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
25. digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

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

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

Ask for an additional sheet if you are taking more than 6 medications

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 _____



DENTAL HISTORY

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:

YES NO

PERSONAL HISTORY

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or reactions to local anesthetic? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE CHARACTERISTICS

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is there anything about the appearance of your teeth that you would like to change? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever whitened (bleached) your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you self conscious about your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been disappointed with the appearance of previous dental work? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you / would you have any problems chewing gum? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you / would you have any problems chewing bagels or other hard foods? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are your teeth crowding or developing spaces? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have tension headaches or sore teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you wear or have you ever worn a bite appliance? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

TOOTH STRUCTURE

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you had any cavities within the past 3 years? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have a dry mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are any teeth sensitive to hot, cold, biting or sweets? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you avoid brushing any part of your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you feel or notice any holes (i.e. pitting) in your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

GUM AND BONE

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you ever experienced gum recession? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Is there anyone with a history of periodontal disease in your family? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do your gums bleed when brushing, flossing or eating? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Are your teeth becoming loose? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever noticed an unpleasant taste or odor in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you experienced a burning sensation in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



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CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please Print

Patient's Name	Last	First	Middle	Date of Birth	Sex	SSN
Patient's Address	Street	Apt #	City	State	Zip	Home Phone
Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W	Patient's Employer			Occupation		
Work Address	Street	City	State	Zip	Work Phone	
Spouse's name	Last	First	Middle	Spouse Employer		Occupation
Work Address	Street	City	State	Zip	Work phone	
Emergency person we can contact (other than your family home)						
Name			Work Phone		Home Phone	
Who can we thank for referring you to our office?				E-Mail		

DEPENDENT INFORMATION

Name _____ (Last) (First) (M.I.) (Nickname)	Sex M ___ F ___	Date of Birth _____
Name _____ (Last) (First) (M.I.) (Nickname)	Sex M ___ F ___	Date of Birth _____
Name _____ (Last) (First) (M.I.) (Nickname)	Sex M ___ F ___	Date of Birth _____
Name _____ (Last) (First) (M.I.) (Nickname)	Sex M ___ F ___	Date of Birth _____

INSURANCE AND FINANCIAL INFORMATION

Insurance Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance Company Name	Insurance Address			
Subscriber's Name	Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Subscriber's Date of Birth	SSN		
Group/Program Number	Employer-If different from above	Employer's Address			
Secondary Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance Company Name	Insurance Address			
Subscriber's Name	Patient's Relationship to Subscriber	Subscriber's Date of Birth	SSN		
Group/Program Number	Employer-If different from above	Employer's Address			

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the service rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Donna, Lisa, or Dr Files

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

This form will be retained in your medical record.

Last Update: ____/____/____



FINANCIAL POLICY

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have an established Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable we are pleased to offer you the following payment options.

1. Cash or Personal Check
2. Visa, MasterCard, American Express or Debit Cards
3. Patient Financing
~ Including Interest Free Financing

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed by you, to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within sixty (60) days of date of service, regardless of whether or not my insurance benefits have been received. One percent (1 ½ %) per month interest, Eighteen percent (18) per year will be charged on accounts 60 days from treatment date. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

Please make your questions and concerns known to our Accounts Manager who is happy to discuss this policy and ensure that you have an outstanding experience.

Signature (responsible party)

Date