LAKES DENTISTRY
LAKEWOOD, WA

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5726 100th St SW
Lakewood, WA 98499

PATIENT INFORMATION

Patients Last Name	First	Middle	Marital Status (Circle One) Single / Mar / Div / Sep / Wid / Partner		
Is this your Legal Name?	If not, what is your legal name	Social Security/Patient ID#	Birth Date	Age	Sex
Home Address City State Zip Code		Home Phone #	Cell Phone #		
Occupation	Employer/School	Work/School Phone #			
Billing Address (if Different) City State Zip Code		Email	Drivers License#		
Chose Us Because/Referred to us by (Please check one box): □ Family □ Friend □ Close to Home/Work □ Internet Search □ Insurance Plan □ Yellow Pages □ Dr. _____ □ Other_____					
Other Family Members Seen Here		Emergency Contact and Phone #			
Primary Insurance:	Subscriber Name	Birth Date / /	Subscriber ID# or Social Security Number		
Secondary Insurance:	Subscriber Name	Birth Date / /	Subscriber ID# or Social Security Number		

DENTAL HISTORY

Please Check "Yes" or "No" to indicate if you have had any of the following:

Bleeding gums	□ Yes	□No	Wear a nightguard or snoring appliance	□ Yes	□No
Bad Breath	□ Yes	□No	Habitual gum chewer	□ Yes	□No
Loose teeth	□ Yes	□No	Do you have more than one bite	□ Yes	□No
Food collection between the teeth	□ Yes	□No	Jaws click, crack, lock or pop	□ Yes	□No
Cigarette, pipe, or cigar smoking	□ Yes	□No	Difficulty chewing your food	□ Yes	□No
Stained or discolored teeth	□ Yes	□No	Hurts to chew or open wide to take a bite	□ Yes	□No
Periodontal Treatment	□ Yes	□No	Jaw pain, tiredness or headaches upon waking	□ Yes	□No
Gum grafting or surgery	□ Yes	□No	Clench or grind your teeth	□ Yes	□No
"Cold Sores" or Blisters on lips/mouth	□ Yes	□No	Have you had blow to the jaw (trauma)	□ Yes	□No
"Canker sores" or growths on mouth	□ Yes	□No	Have a jaw disorder (TMD)	□ Yes	□No
Sensitivity when biting	□ Yes	□No	Dry mouth	□ Yes	□No
Sensitivity to cold, heat, sweets	□ Yes	□No	Radiation to the mouth	□ Yes	□No
Mouth pain	□ Yes	□No	Mouth breathing	□ Yes	□No
Loose or broken fillings	□ Yes	□No	Orthodontic treatment (braces)	□ Yes	□No
Broken or cracked teeth	□ Yes	□No	Use a fluoride mouthwash or prescription fluoride	□ Yes	□No
Gag easily	□ Yes	□No	Use a power tooth brush	□ Yes	□No
Loose or ill fitting partials or dentures	□ Yes	□No	Apprehensive about dental treatment	□ Yes	□No
Fingernail biting	□ Yes	□No	Dissatisfied with the appearance of your teeth	□ Yes	□No
Burning sensation on tongue	□ Yes	□No	Problems with anesthetic or previous dental treatment	□ Yes	□No
How often do you brush? Floss?			**Name of Previous Dentist** **City, State**		
Use any other hygiene aids?			**Date of Last Visit to Dentist**		

MEDICATIONS

Please list all medications that you are currently taking and for what condition:

MEDICAL HISTORY

Name of your Medical Doctor	**Date of last visit to Medical Doctor**

Please check "Yes" or "No' to indicate if you have had any of the following:

Chest Pain	□Yes	□No	Sinus Trouble	□Yes	□No	Persistent or bloody cough	□Yes	□No
Shortness of breath	□Yes	□No	Asthma	□Yes	□No	Tuberculosis	□Yes	□No
Blood pressure problem	□Yes	□No	Allergy Problems	□Yes	□No	Emphysema	□Yes	□No
Heart murmur	□Yes	□No	Cancer/Tumor	□Yes	□No	Respiratory Disease	□Yes	□No
Heart valve problem	□Yes	□No	Previous Biopsies	□Yes	□No	Sjogren's Disease	□Yes	□No
Taking heart medication	□Yes	□No	Radiation Treatment	□Yes	□No	Arthritis, Rheumatism	□Yes	□No
Rheumatic fever	□Yes	□No	Chemotherapy	□Yes	□No	Bone or Joint Problems	□Yes	□No
Pacemaker	□Yes	□No	Prosthetic joints	□Yes	□No	Circulatory Problems	□Yes	□No
Artificial heart valve	□Yes	□No	Thyroid Problems	□Yes	□No	Acid Reflux/GERD	□Yes	□No
Mitral Valve Prolapse	□Yes	□No	Stroke(s)	□Yes	□No	Glaucoma	□Yes	□No
Heart Surgery	□Yes	□No	HIV Positive	□Yes	□No	ADHD medications	□Yes	□No
Heart Attack or Heart Disease	□Yes	□No	AIDS	□Yes	□No	Fibromyalgia	□Yes	□No
Taking Anticoagulants (Coumadin)	□Yes	□No	Kidney Disease	□Yes	□No	Back or neck pain	□Yes	□No
Anemia or Blood Disorder	□Yes	□No	Bladder Problem	□Yes	□No	Cortisone Treatments	□Yes	□No
Ever require a blood transfusion?	□Yes	□No	Liver Disease	□Yes	□No	History of head injury	□Yes	□No
Abnormal bleeding with extractions or surgery	□Yes	□No	Women: Are you pregnant or nursing?	□Yes	□No	Premedications required by physican	□Yes	□No
Special Diet/Weight loss or gain	□Yes	□No	Hepatitis (Type____)	□Yes	□No	Neurological disease	□Yes	□No
Weight loss surgery	□Yes	□No	Psychiatric Care	□Yes	□No	Fainting or dizziness	□Yes	□No
Intestinal Problems	□Yes	□No	Organ Transplant	□Yes	□No	Seizures or Epilepsy	□Yes	□No
Crohn's Disease	□Yes	□No	Chemical Dependency	□Yes	□No	C-PAP machine	□Yes	□No
Autoimmune disease or Lupus	□Yes	□No	Do you chew tobacco	□Yes	□No	Sleep Apnea	□Yes	□No
Diabetes Type ___ What is your insulin level_____	□Yes	□No	Do you smoke? How much_____	□Yes	□No	Ever taken osteoporosis medication	□Yes	□No
Have you ever taken any prescriptions drugs such as Fen-Phen for weight loss							□Yes	□No
Have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)?							□Yes	□No

ALLERGIES

Are you allergic, or have you reacted adversely to any of the following?

Local Anesthetics ("Novocain")	□Yes	□No	Latex or Rubber Dam	□Yes	□No
Penicillin or other Antibiotics	□Yes	□No	Reaction to Metals	□Yes	□No
Sulfa Drugs	□Yes	□No	Codeine, Demerol, or other narcotics	□Yes	□No
Barbiturates, Sedatives or Sleeping pills	□Yes	□No	Aspirin, Acetaminophen, or Ibuprofen	□Yes	□No
Mint, Food Coloring, or Fragrance	□Yes	□No	Other	□Yes	□No

I understand that the information is correct to the best of my knowledge. I understand that it will be used to improve communication between the dental provider and myself. It is my responsibility to inform the dental office of any changes in my medical history. Signature_____ Date:_____

Health History Update

Date	Staff Init	Health Changes	Current Medications	BP/Pulse