



821 N Wenatchee Ave • Wenatchee WA 98801 • (509) 663-1566

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. Thank You.

PATIENT'S NAME \_\_\_\_\_ Preferred Name \_\_\_\_\_

Married    Single    Divorced    Separated    Widowed

Male    Female   Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_   Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Mailing Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

*Whom may we thank for referring you?* \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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 \_\_\_\_\_

## DENTAL HISTORY

Chief dental concern: \_\_\_\_\_

- Are you nervous about having dental treatment?  Yes  No
- Have you ever had a bad dental experience?  Yes  No
- Do you have difficulty or pain when opening (yawning)?  Yes  No
- Does your jaw get stuck, locked or "go out"?  Yes  No
- Difficulty / pain when chewing, talking, or using your jaws?  Yes  No
- Teeth?  Yes  No
- Do you have noises in your jaw joints?  Yes  No
- Pain about the ears, temples or cheeks?  Yes  No
- Does your bite feel uncomfortable or unusual?  Yes  No
- Are you aware of grinding your teeth?  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 disease?  Yes  No
- Are your teeth sensitive to cold / heat / etc?  Yes  No
- Have you ever been premedicated for dental work?  Yes  No
- Do you have frequent Headaches?  Yes  No
- Are you happy with the way your smile looks?  Yes  No
- If not, what would you change? \_\_\_\_\_

## HEALTH HISTORY

- Are you having any pain or discomfort at this time?  Yes  No
- Do you smoke or use tobacco in any form?  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
- Physician Name \_\_\_\_\_
- Address \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently taking any medications / drugs?  Yes  No

If yes, please list: \_\_\_\_\_

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:

- |  |  |  |  |
|--|--|--|--|
| <p><b>Y N</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Angina Pectoris</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Disease / Attack / Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Failure</p> <p><input type="checkbox"/> <input type="checkbox"/> High / Low Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Murmur / Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Pacemaker</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Transfusion / Anemia</p> | <p><b>Y N</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Bruise Easily</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Disease / Yellow Jaundice</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Failure/Disfunction</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> Chemotherapy / Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> X-ray /Radiation Treatment</p> <p><input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery</p> | <p><b>Y N</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema / Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Cough / Tuberculosis (TB)</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis / Rheumatism</p> <p><input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> A.I.D.S. / H.I.V.</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis: A B C (<b>circle one</b>)</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joint</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Joints (Hip, Knee)</p> <p><input type="checkbox"/> <input type="checkbox"/> Scarlet Fever</p> | <p><b>Y N</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Fever Blisters / Cold Sores</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting / Dizzy Spells</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Hay Fever / Sinus Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies / Hives</p> <p><input type="checkbox"/> <input type="checkbox"/> Shingles</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> <input type="checkbox"/> Psychiatric Treatment</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug / Alcohol Addiction</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood thinner</p> <p><input type="checkbox"/> <input type="checkbox"/> Splenectomy</p> |
|--|--|--|--|

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

- |   |  |
|---|--|
| <input type="checkbox"/> Antibiotics      | <input type="checkbox"/> Aspirin                 |
| <input type="checkbox"/> Codeine          | <input type="checkbox"/> Latex                   |
| <input type="checkbox"/> Metals / Jewelry | <input type="checkbox"/> 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. I also give permission to Riverway Family Dental and/or the staff to use any photos taken for lecturing and continuing education purposes.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Medical History Update

(For Office Use Only)

Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____