Auburn dental center

PATIENT INFORMATION & HISTORY (CONFIDENTIAL)

Patient Information (Please Fill Out Completely)

Name _____ SS#_____ Birthdate _____ Driver's License #_____

Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Cell Phone (_____)_____ Email _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married If Minor, Parent's Name_____

How Did You Hear About Our Office? ☐ Website ☐ Google Ad ☐ Facebook ☐ Yelp ☐ Insurance Provider

☐ Existing Patient: _____ ☐ Other _____

Emergency Contact _____ Relationship _____ Phone # (_____)_____

Responsible Party (Please Fill Out Completely)

Name of Person Responsible for This Account _____ Relation to Patient _____

Address _____ Home Phone (_____)_____

Employer_____ Work Phone (_____)_____

Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information (Please Fill Out Completely)

Name of Insured _____ Relation to Patient_____

Birthdate _____ SS#_____ Date Employed _____

Employer _____ Work Phone (_____)_____

Insurance Company _____ Group #_____ Union or Local #_____

Address _____ City _____ State _____ Zip _____

Secondary Insurance Information (If Applicable)

Name of Insured _____ Relation to Patient _____

Birthdate _____ SS#_____ Date Employed _____

Employer _____ Work Phone (_____)_____

Insurance Company _____ Group #_____ Union or Local #_____

Address _____ City _____ State _____ Zip_____

Release

- I authorize Auburn Dental Center's Doctors to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claim for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
- I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental or medical care payor.
- I understand that I am financially responsible for payment in full of all accounts. Finance charges of 1.5% monthly will be applied to balances due over 90 days (per RCW 19.52), which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance.

PATIENT'S OR PARENT'S SIGNATURE _____ DATE _____

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DENTAL / MEDICAL HISTORY
(CONFIDENTIAL – PAGE 1)

Dental History

Reason for today's visit_____ Date of last dental visit_____

Former Dentist_____ Date of last dental X-rays _____

Address _____

Check if you have had any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food Collection Between Teeth
- ☐ Grinding Teeth
- ☐ Loose Teeth or Broken Fillings
- ☐ Past Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting
- ☐ Sores or Growths in Your Mouth

Are you apprehensive about dental treatment? _____

Have you ever had local anesthetic (Novocain, etc.) _____

Are you dissatisfied with the appearance of your teeth? _____

Medical History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively called "Bisphosphonates" (examples of common bisphosphonates include Fosamax, Boniva, Actonel, etc.)? ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, please describe _____

Have you had a blood transfusion? ☐ Yes ☐ No If yes, please give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Have you been told by your medical provider that you need to take antibiotics before dental treatment? ☐ Yes ☐ No

Check if you have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Persistent Cough
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Medications

List Medications you are currently taking and the correlating diagnosis

_____

_____

_____

_____

_____

Allergies

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Antibiotics _____
- ☐ Other _____

Auburn dental center

DENTAL / MEDICAL HISTORY
(CONFIDENTIAL – PAGE 2)

Sleep / Snore History

☐ Yes	☐ No	Do you snore, or have you been told you snore?
☐ Yes	☐ No	Are you ever tired during the day?
☐ Yes	☐ No	Have you been told you quit breathing during sleep or awaken suddenly in your sleep?
☐ Yes	☐ No	Do you ever wake up with headaches in the morning?
☐ Yes	☐ No	Have you been told to wear a CPAP device, or do you wear a CPAP device?
☐ Yes	☐ No	Have you ever been asked to, or have you taken a sleep study?

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Please circle below.

	Chance of Dozing			
	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Additional Information

Please indicate any additional areas you are interested in having the doctor discuss with you.

Orthodontics
- ☐ Invisalign

Cosmetic Dentistry
- ☐ Veneers
- ☐ Teeth Whitening

Others
- ☐ Headaches, Migraines, TMD
- ☐ Bruxism (Teeth Grinding)

Signature

I certify that the above information is accurate and complete to the best of my knowledge. I will not hold Auburn Dental Center or any of their staff responsible for any errors or omissions that I may have made in the completion of this form. I will inform the doctor if my health or medication changes in any way.

PATIENT'S OR PARENT'S SIGNATURE _____ DATE _____