MINAHAN DENTAL

17191 Bothell Way NE
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Lake Forest Park, WA 98155
(206) 365 5454

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

General Information

Patient name _____ Today's date _____

Social Security No. _____ Date of birth _____

Age _____ Sex _____ Driver's license No. _____

Home address _____ Phone Cell phone _____

Billing address (if different from above) _____

Employer/occupation Business phone _____

Spouse's name _____ Spouse's phone _____

Emergency phone (other than spouse) _____

Primary dental insurance Group No. _____

Secondary dental insurance Group No. _____

Subscriber's name _____

Subscriber's Social Security No. _____

Date of birth _____ Age _____ Sex _____

Name of your medical doctor _____ Date of last visit to medical doctor _____

Name of previous dentist _____ Date of last visit to dentist _____

Referred to us by _____

Dental Health History

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐

	Yes	No
Have you ever noticed slow-healing sores in or around your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:	☐	☐
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sour foods?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐

Dental Health History (Continued)

	Yes	No
Do you want complete dental care?	☐	☐
How often do you brush?	☐	☐
How often do you floss?	☐	☐
Does your jaw make noise so that it bothers you?	☐	☐
or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

Medical Health History

Do you have or have you had any of the following? (check all that apply)

Heart problems	☐	Special diet	☐
Chest pain	☐	Constipation/diarrhea	☐
Shortness of breath	☐	Kidney or bladder problems	☐
Blood pressure problem	☐	Fainting spells, seizures or epilepsy	☐
Heart murmur	☐	Stroke(s)	☐
Heart valve problem	☐	Frequent or severe headaches	☐
Taking heart medication	☐	Thyroid problems	☐
Rheumatic fever	☐	Persistent cough or swollen glands	☐
Pacemaker	☐	Premedications required by physician	☐
Artificial heart valve	☐	Cancer/tumor	☐
Blood problems	☐	Diabetes	☐
Easy bruising	☐	Urinate more than six times a day	☐
Frequent nosebleed/Abnormal bleeding	☐	Thirsty or mouth is dry much of the time	☐
Blood disease	☐	Family history of diabetes	☐
Anemia	☐	Tuberculosis or other respiratory disease	☐
Ever require a blood transfusion?	☐	Do you drink alcohol?	☐
Allergy problems	☐	If so, how much?	
Hay fever	☐	Hepatitis, jaundice or liver trouble	☐
Sinus problems	☐	Herpes or other STD	☐
Skin rashes	☐	HIV positive/AIDS	☐
Taking allergy medication	☐	Glaucoma	☐
Asthma	☐	Do you wear contact lenses?	☐
Intestinal problems	☐	Head injury	☐
Ulcers	☐	Epilepsy or other neurologic disease	☐
Weight gain or loss	☐	History of alcohol or drug abuse	☐

Medical Health History (Continued)

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Other		

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

	Yes	No
Local anesthetics (“Novocain”)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐
Aspirin, acetaminophen or ibuprofen	☐	☐
Codeine, Demerol or other narcotics	☐	☐
Metals	☐	☐
Latex or rubber dam	☐	☐

Please list current medications:

Women:

	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms?		

Date

Patient signature/legally authorized representative

Relationship

Printed name if signed on behalf of the patient

Date

Dentist signature