Commencement Bay DENTISTRY

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Tacoma, WA 98403

## PATIENT INFORMATION

| Patients Legal Last Name | Legal First Name | Middle Name | Preferred Name | Marital Status (Circle One) Single / Mar / Div / Sep / Wid /Partner |
|---|---|---|---|---|
| | | | | |

| Birth Date | Assigned Sex at Birth | Preferred pronouns | Social Security/Patient ID# | Emergency Contact and Phone #: |
|---|---|---|---|---|
| | | | | |

| Home Address | City | State | Zip Code | Home Phone # | Cell Phone # |
|---|---|---|---|---|---|
| | | | | | |

| Occupation | Employer/School | Other Family Members Seen Here: |
|---|---|---|
| | | |

| Email | Drivers License# |
|---|---|
| | |

Chose Us Because/Referred to us by: □ Family/Friend/Co-worker_____ □ Close to Home/Work
□ Internet Search □ Insurance Plan □ Dr. _____ □ Other_____

## DENTAL HISTORY

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

| | | | | | |
|---|---|---|---|---|---|
| Loose or broken fillings or teeth | □ Yes | □No | Wear a nightguard or snoring appliance | □ Yes | □No |
| Sensitivity to cold, heat, sweets | □ Yes | □No | Fingernail biting | □ Yes | □No |
| Sensitivity when biting | □ Yes | □No | Jaws click, crack, lock or pop or jaw disorder (TMD) | □ Yes | □No |
| Food collection between the teeth | □ Yes | □No | Difficulty chewing your food or hurts to open wide | □ Yes | □No |
| Gag easily | □ Yes | □No | Jaw pain, tiredness or headaches upon waking | □ Yes | □No |
| Periodontal treatment/Deep cleanings | □ Yes | □No | Clench or grind your teeth/Jaw | □ Yes | □No |
| Gum grafting or surgery | □ Yes | □No | Have you had blow to the jaw (trauma) | □ Yes | □No |
| Bleeding gums | □ Yes | □No | Loose or ill fitting partials or dentures | □ Yes | □No |
| Mouth breathing | □ Yes | □No | Orthodontic treatment (braces) | □ Yes | □No |
| "Canker sores" or growths on mouth | □ Yes | □No | Use a fluoride mouthwash or prescription fluoride | □ Yes | □No |
| "Cold Sores" or Blisters on lips/mouth | □ Yes | □No | Use a power tooth brush | □ Yes | □No |
| Burning mouth syndrome | □ Yes | □No | Apprehensive about dental treatment | □ Yes | □No |
| Dry mouth | □ Yes | □No | Dissatisfied with the appearance of your teeth | □ Yes | □No |
| Radiation to the mouth | □ Yes | □No | Problems with anesthetic or 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: (or attach List)**

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# 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:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Attack or Heart Disease | □Yes | □No | Radiation Treatment | □Yes | □No | Emphysema | □Yes | □No |
| Pacemaker/Heart surgery | □Yes | □No | Chemotherapy | □Yes | □No | Allergy Problems | □Yes | □No |
| Blood pressure problem | □Yes | □No | Cancer or Tumor | □Yes | □No | Respiratory Disease | □Yes | □No |
| Heart murmur | □Yes | □No | Sjogren's Disease | □Yes | □No | Asthma | □Yes | □No |
| Mitral Valve Prolapse | □Yes | □No | Stroke(s) | □Yes | □No | Neurological disease | □Yes | □No |
| Taking heart medication | □Yes | □No | HIV/AIDS | □Yes | □No | Arthritis, Rheumatism | □Yes | □No |
| Autoimmune disease or Lupus | □Yes | □No | Hepatitis | □Yes | □No | Bone or Joint Problems | □Yes | □No |
| Special Diet/Weight loss or gain | □Yes | □No | Kidney Disease | □Yes | □No | Persistent/bloody cough | □Yes | □No |
| Weight loss surgery | □Yes | □No | Liver Disease | □Yes | □No | Tuberculosis | □Yes | □No |
| Intestinal Problems/Crohn's Disease | □Yes | □No | Diabetes (Type _____) | □Yes | □No | Seizures or Epilepsy | □Yes | □No |
| Women: Are you pregnant/nursing? | □Yes | □No | Hepatitis (Type_____) | □Yes | □No | Thyroid Problems | □Yes | □No |
| Prosthetic joints/Knee replacement | □Yes | □No | C-PAP machine | □Yes | □No | Fibromyalgia | □Yes | □No |
| Premedication required by physician | □Yes | □No | Sleep Apena | □Yes | □No | Back or neck pain | □Yes | □No |
| Taking Anticoagulants (Coumadin) | □Yes | □No | Psychiatric Care | □Yes | □No | Tobacco use/Vaping | □Yes | □No |
| Abnormal bleeding with extractions | □Yes | □No | Suicidal thoughts | □Yes | □No | Marijuana use | □Yes | □No |
| Anemia or Blood Disorder | □Yes | □No | Chemical Dependency | □Yes | □No | Fibromyalgia | □Yes | □No |
| Ever taken osteoporosis medication | □Yes | □No | Acid Reflux/GERD | □Yes | □No | Other:_____ | □Yes | □No |
| Have you ever been treated with Bisphosphonate drugs (Fosamax, Prolia,Reclast, Aredia, Zometa, Actonel, Boniva)? | | | | | | | □Yes | □No |

# ALLERGIES

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

| | | | | | |
|---|---|---|---|---|---|
| Local Anesthetics ("Novocaine") | □Yes | □No | Latex or Rubber Dam | □Yes | □No |
| Penicillin, Sulfa or other Antibiotics | □Yes | □No | Reaction to Metals | □Yes | □No |
| Codeine, Demerol, or other Narcotics | □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 my dental office of any changes in my medical history. Signature_____Date:_____

## Health History Update

| Date | Health/Medication Changes | Date | Heath/Medication Changes |
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