

ROGER FLAKE, D.D.S.

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Please answer all questions on **both** pages, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

PATIENT'S NAME _____ Nickname _____

(Please Circle) { Male { Female Social Security No. _____ Birthdate _____ Age _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Best Way to Contact _____

Occupation _____ Employer _____ Address _____

(Please Circle) { Married { Single { Divorced { Separated { Widowed

Name of Spouse _____ Birthdate _____ Social Security No. _____

Spouse Occupation _____ Employer _____ Work Phone _____

PAYMENT IS EXPECTED AT TIME OF EACH VISIT

PLEASE CIRCLE METHOD OF PAYMENT:

{ Cash { Check { Bankcard

PRIMARY DENTAL INSURANCE

Employee _____
Relationship to Patient _____
Employer _____
Insurance Co. _____ Group # _____
Insured Birthdate _____
Employee's S.S. No. _____

SECONDARY DENTAL INSURANCE

Employee _____
Relationship to Patient _____
Employer _____
Insurance Co. _____ Group # _____
Insured Birthdate _____
Employee's S.S. No. _____

Person Responsible for Payment _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Phone _____ Work Phone _____

Relationship to Patient _____ Closest Relative _____ Phone No. _____

How did you hear of us: Friend/Relative (Name) _____ Insurance Co. _____

Drive-by _____ ValPak _____ Yellow Pages _____ Other _____

DENTAL HISTORY

Are you nervous about having dental treatment?	Yes	No	Do your teeth feel loose?	Yes	No
Have you ever had a bad dental experience?	Yes	No	Do your gums ever bleed?	Yes	No
Do you have difficulty or pain when opening?	Yes	No	Does food catch between your teeth?	Yes	No
Does your jaw get stuck, locked, or go out?	Yes	No	Any difficulty chewing your food?	Yes	No
Difficulty/pain when chewing, talking, using jaw?	Yes	No	Have you ever had periodontal disease?	Yes	No
Do you have noises in your jaw joint?	Yes	No	Are your teeth sensitive to cold/heat/etc?	Yes	No
Does your bite feel uncomfortable or unusual?	Yes	No	Do you have frequent headaches?	Yes	No
Have you had an injury to your head/jaw?	Yes	No	Pain about the ears, temples or cheeks?	Yes	No
Have you been treated for a jaw joint problem?	Yes	No	Previous Dentist's Name _____		
Have you ever been premedicated for dental work?	Yes	No	Chief dental concern? _____		
Are you interested in whitening your teeth?	Yes	No			
If you could change one thing about your smile what would it be? _____					

HEALTH HISTORY

Are you having any pain or discomfort at this time?	Yes	No	Are you currently taking any medications?	Yes	No
Have you been hospitalized in the past 2 years?	Yes	No	Have you taken any meds/drugs in past 2 yrs?	Yes	No
Are you under the care of a doctor?	Yes	No	Do you smoke or use tobacco in any form?	Yes	No
Physician's Name _____			Women: Are you pregnant	Yes	No
Address _____ Phone _____			Please list any medications you are currently taking:		
Please list any serious medical conditions that you have/had:			_____		
_____			_____		
_____			_____		

Please check any of the following which you have now or have had in the past?

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

Angina Pectoris	Cosmetic Surgery	Latex	Penicillin
Heart Disease/Attack/Stroke	Emphysema / Asthma	Nitrous Oxide	Erythromycin
Heart Failure	Cough / Tuberculosis (TB)	Local Anesthetic	Tetracycline
High/Low Blood Pressure	Arthritis / Rheumatism	Aspirin	Other Antibiotics
Congenital Heart Defect	Cortisone Medicine	Codeine	Darvon
Heart Murmur/Rheumatic Fever	Venereal Disease	Demerol	Metals/Jewelry
Heart Surgery	A.I.D.S. / H.I.V.	Percodan	Sleeping Pills
Heart Pacemaker	Diabetes	Scopolamine	Valium
Artificial Heart Valve	Frequent Headaches	Are you allergic to any other medications, foods, or other substances? _____	
Hepatitis: A (infectious) B (serum)	Pain in Jaw Joint	_____	
Blood Transfusion/Anemia	Artificial Joints (Hip, Knee)	_____	
Sickle Cell Disease	Scarlet Fever	_____	
Bruise Easily	Fever Blisters/Cold Sores		
Hemophilia	Fainting/Dizzy Spells		
Liver Disease/Yellow Jaundice	Epilepsy Seizures		
Kidney Failure/Dysfunction	Hay Fever/Sinus Trouble		
Thyroid Disease	Allergies/Hives		
Ulcers	Shingles		
Glaucoma	Nervousness/Depression		
Chemotherapy/Cancer	Psychiatric Treatment		
X-ray / Cobalt Treatment	Drug/Alcohol Addiction		

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 understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover. **A charge of \$75.00 could be applied to your account for failed or cancelled appointments without a 48-hour notice.**

Patient's Signature _____ **Date** _____