Olympic View Dental

Name		Hm Phone
Address		Email
City State Zip		Cell Phone
ε M ε F	ε Single ε Married	Date of Birth ____/_____/____AGE __________
Which contact phone number / email do you prefer	Home / Cell / Work / Email	
Employer	SS # ________-______-________	
Employers Phone	Is it okay to contact you at work? Y / N	
Who may we thank for referring you?		
Emergency Contact: Name		Phone

Primary Insurance	Secondary Insurance
Insurance Company ______________________________	Insurance Company ______________________________
Name of Insured ______________________________	Name of Insured ______________________________
Relationship to Patient ______________________________	Relationship to Patient ______________________________
Subscriber's Name ______________________________	Subscriber's Name ______________________________
Subscriber's SS# ________-________-________	Subscriber's SS# ________-________-________
Subscriber's DOB ________/________/________	Subscriber's DOB ________/________/________

DENTAL HISTORY

Reason for today's visit: ______________________________________Former Dentist:_______________________________

Check any that apply:
- ε Periodontal Treatment
- ε Orthodontic Treatment
- ε Loose teeth/Broken fillings
- ε Dry Mouth
- ε Jaw Pain
- ε Clicking/Popping jaw

Do you wear dentures or partials? Y N

ε Upper Denture / Partial
ε Age of appliance________

ε Lower Denture / Partial
ε Age of appliance_________

RESPONSIBILITIES AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure payment of benefits.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ____ Date ________________

Relationship to Patient____

HEALTH HISTORY

Physicians Name ______________________________________ Date of last visit:________________________

Please check any that apply

ε Diabetes
ε Thyroid Problems
ε Shortness of Breath
ε Asthma
ε COPD (Emphysema, Bronchitis)
ε TB
ε Heart Murmur
ε Rheumatic Fever
ε High Blood Pressure
ε Angina/Chest Pain
ε Heart Attack
ε Pacemaker
ε Stroke
ε Other Heart Problems
ε Bleeding Disorder/Abnormal Bleeding
ε Autoimmune Disorder
ε Head Aches
ε Jaw Pain
ε Gastrointestinal Problems/Ulcers/Reflux
ε Kidney Problems
ε Liver Problems
ε Hepatitis Type:________
ε Jaundice
ε Cancer (radiation/chemotherapy)
ε Skin/Muscle/Bone Problems
ε Nervous Problems
ε Seizures
ε Blood Transfusions
ε Smoker How many per day __________
ε Alcohol How many drinks per week _________
ε Recreational Drug Use
ε STD / HIV / AIDS
ε Trauma
ε Surgeries/Hospitalizations________________________
____
____

Women:
Are you pregnant? Y N Due Date:______________________ Are you nursing? Y N

MEDICATIONS
List any medications you are currently taking:
____
____
____
____

ALLERGIES
List any allergies you have including to medications:
____
____
____
____

DOCTOR USE ONLY

UPDATES

Have there been changes in health since last visit? Y N
____
____
New Medications:___________________________________
____
____

MODIFICATIONS TO TREATMENT

Anesthetic: ______________________________________
N2O: ____
PreMed: ____
Other: ____
____
____

(Please note date of update)