URBAN DENTAL

FAMILY COSMETIC IMPLANT DENTISTRY

9015 Holman Rd NW Suite 5 Seattle, WA 98117 (206)-913-2256 Office (206)-913-2259 Fax
UrbanDentalSeattle@gmail.com

ABOUT YOU (patient information)

Today's Date:_____ Would you like an e-mail reminder? □Yes □No E-mail Address:_____

Name:_____I prefer to be called:_____□Male□Female
Last First MI Mr. Mrs. Miss Dr. □Single □Married □Divorced □Widowed □Separated

Home Address:_____
Street City State Zip

Phone#(____)_____DOB:_____SSN#_____DL#_____

Where and when Is the best time to reach you?_____ **How did you hear about us**?_____

Employer:_____ Occupation:_____Work#(____)_____

Dental Insurance Company:_____Subscriber ID#_____

Person Responsible for Account if other than yourself (Parent/Legal Guardian) or Covered under Spouses Insurance

Name:_____ Relation:_____ DOB:_____ SSN#_____
Phone:(____)_____Employer:_____ Work#(___)_____ Ext:_____
Billing Address:_____
Street City State Zip
Dental InsuranceCompany:_____Subscriber:ID#_____

Emergency Contact Information

Name:_____ Relation:_____ DOB:_____ Phone# (____)_____
Employer:_____ Work#(___)_____ Ext:_____
Home Address:_____
Street City State Zip

Dental History

Why have you come to the dentist today?_____
_____
Do you require antibiotics before dental treatment? □Yes □No
When was your last dental exam?____/____/____
How often do you floss? # times/day_____
How often do you brush? # times/day_____
Do you grind your teeth? □Yes □No
Have you ever had orthodontic braces treatment? □Yes □No
Have you ever had periodontal (gum) treatments? □Yes □No
Do you smoke, vape or use tobacco? □Yes □No

Do you have any of the following?

□Bad Breath	□Difficulty Open/Close	□Mouth Pain
□Bleeding Gums	□Difficulty chewing	□Mouth Sores
□Blisters on mouth	□Dry Mouth	□Partials
□Broken Fillings	□Ear Pain	□Swollen Gums
□Clicking Jaw	□Jaw Pain	
□Dentures	□Loose Teeth	

Are you sensitive to?

□Cold □Heat □Sweets □Pressure

For Women

Are you taking birth control pills? □Yes □No
Week #_____

Are you pregnant? □Yes □No □Not Sure
Are you Nursing? □Yes □No

Medical Health History

Do you have or have you experienced the following? Check all that apply

□Are you **required to pre-medicate** before any dental treatment?

□Abnormal Bleeding
□Alcohol Abuse
□Anemia
□Arthritis
□Artificial Bones/Joints __/__/__
□Asthma
□Cancer
□Chemotherapy __/__/__
□Cholesterol
□Chicken Pox
□Colitis
□Congenial
□Venereal Disease
□Diabetes
□Difficulty Breathing
□Drug Abuse
□Emphysema
□Epilepsy
□Fainting Spells
□Fever Blisters
□Glaucoma
□Hay Fever
□Heart Attack __/__/__
□Heart Murmur
□Heart Defect
□Hemophilia
□Headaches
□Herpes
□Hepatitis ____
□High/Low Blood Pressure
□HIV/AIDS
□Kidney Problems
□Liver Disease
□Lupus
□Mitral Valve Prolapsed
□Pacemaker
□Heart Surgery __/__/__
□Psychiatric Problems
□Radiation __/__/__
□Seizures __/__/__
□Shingles
□Sickle Cell Disease
□Sinus Problems
□Steroid Problem
□ Stroke ___/___/___
□Thyroid Problems
□ Tonsillitis
□Tuberculosis(TB)
□ Persistent Cough

Please List any other serious medical condition(s) that you have:_____

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

□Aspirin □Barbiturates, sedatives □Other:_____
□Codeine □Dental Anesthetic
□Latex □Jewelry/metals:_____
□Antibiotics:_____

Are you taking any of the following:

□Aspirin □Anticoagulants (Blood thinners e.g. Coumadin)
□Antibiotics □Cortisone or other steroids □Nitroglycerin
□High Blood Pressure medication □Natural Supplements
□Insulin other diabetes drugs □Sulfa Drugs
□Osteoporosis Medication □Other

Current medications

Are you currently taking any blood thinners? □Yes □No

What medications are you taking right now?

Name	Dosage	Frequency

Hospitalizations & Surgeries

Reason	Date

Medical Provider Information

ClinicName:_____Physicians Name_____OfficePhone#_____

Clinic Address:_____

Street City State Zip

Your current physical health is: □Good □Fair □Poor Date of your last visit:_____

AUTHORIZATIONS

I affirm that the information above is correct. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I will not hold my doctor, or any member of their staff, responsible for any errors or omissions that I have made in completing this form. I authorize the dental staff to perform the necessary dental services I may need.

PAYMENT IS DUE AT THE TIME OF SERVICE

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA **I certify that I am covered by _____ insurance Co.** and I assign directly to **Dr. Jean-Pierre Truong** all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductable that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature, whether manual or electronic.

_____ _____

Signature of Patient **Date**

Dentist Signature:_____ **Date:**_____