Burien Family Dental Care

JOSEPH LEE, DMD, PS

Date _____

PATIENT INFORMATION

Name _____

Nickname _____

Male _____ Female _____

Marital Status _____

DOB ____/____/____ SSN _____

Home Address _____

City _____ **St** _____ **Zip** _____

Cell Phone _____

Home Phone _____

Work Phone _____

Email _____

Patient's Employer _____

Occupation _____

How did you hear about our office? If referred, whom may we thank?

_____

Please list other family members seen by us:

_____

_____

_____

Permission for treatment - I hereby grant permission to Dr. Lee and staff to recommend and complete treatments and therapy as deemed necessary.

The information I have given today is true to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status.

Financial Agreement - All charges for services and treatment will be paid upon completion of appointment, unless other arrangements have been made. Outstanding balances shall accrue interest monthly.

If insurance is involved - I hereby authorize payment directly to Dr. Lee of insurance benefits which may otherwise be payable to me.

Broken Appointments - I understand that appointments changed without 24 hours notice may be assessed a broken appointment charge of $50/hour.

_____

Patient, Guardian, or Guarantor's Signature

BILLING INFORMATION

(Complete this only if billing information is different from patient information section)

Person Responsible for Account or Insured

_____

Relationship to Patient _____

Billing Address _____

City _____ St _____ Zip _____

Home Phone _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Subscriber's Name _____

Subscriber's DOB ____/____/____

Subscriber's SSN or ID# _____

Subscriber's Relationship to Patient _____

Employer _____

Dental Insurance _____

Dental Insurance Phone Number _____

Group # _____

SECONDARY INSURANCE

Subscriber's Name _____

Subscriber's DOB ____/____/____

Subscriber's SSN or ID# _____

Subscriber's Relationship to Patient _____

Employer _____

Dental Insurance _____

Dental Insurance Phone Number _____

Group # _____

EMERGENCY CONTACT

Name _____

Relationship _____

Phone _____

MEDICAL HISTORY

Your current physical health is

☐ Good ☐ Fair ☐ Poor

Physician's Name _____

Physician's Phone _____

Are your currently under a physician's care? ☐ Y ☐ N

Please explain _____

_____

Do you smoke or use tobacco products? ☐ Y ☐ N

_____

List any prescription or over the counter medications you are currently taking:

Medication: Used for

_____

_____

_____

_____

_____

_____

_____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Latex
Y N Codeine	Y N Metals (i.e. jewelry)	Y N Penicillin
Y N Tetracycline	Y N Dental Anesthetics	Y N Other

For Women: Are you pregnant? ☐ Y ☐ N

due date _____

Are you nursing? ☐ Y ☐ N

DENTAL HISTORY

How long since last dental exam? _____

Have you ever experienced unfavorable dental treatment?

_____

Is there anything that you would like to change about your smile? ☐ Y ☐ N _____

Do you now have or have you ever experienced discomfort in your jaw joint (TMJ)? ☐ Y ☐ N

Are you interested in whitening? ☐ Y ☐ N

Are you apprehensive about dental treatment?

☐ Y ☐ N

Have you ever had any of the following diseases or medical conditions?

Y N Allergies Specify:_____
Y N Anemia
Y N Anginal/Chest Pains
Y N Arthritis
Y N Artificial Joints
Y N Artificial Heart Valves
Y N Asthma
Y N Cancer/Chemotherapy/Radiation
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema
Y N Epilepsy/Seizures
Y N Fainting Spells
Y N Frequent Headaches
Y N Frequent Mouth Sores
Y N Glaucoma
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis Type:_____
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized
Y N Hypothyroid/Hyperthyroid
Y N Kidney Problems
Y N Liver Disorder
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Shingles
Y N Sinus Problems
Y N Stroke
Y N Tuberculosis
Y N Tumor Benign/Malignant
Y N Ulcers

Are you currently taking any blood thinners?
☐ Y ☐ N

Have you ever taken Fosamax or any other Biophosphonate drug?
☐ Y ☐ N

Have you ever been treated for osteoporosis?
☐ Y ☐ N

Have you ever been treated for bone disease?
☐ Y ☐ N

Why are you now seeking dental treatment?

_____

_____

For Office Use Only:

Pacemaker	Allergies	Heart Condition	Pre Med	No Epi	Latex	Nitrous Oxide	Other