ROOSEVELT
DENTAL CENTER

L. Douglas Gray, DDS
Arman Abedi, DDS

6417 Roosevelt Way NE, Suite 206 Seattle, WA 98115. 206-524-6100

Name _____ Date _____

Address _____ Phone _____

_____ Zip Code _____ Social Security # _____

Occupation _____ Birthdate _____

Employer _____ Work Phone _____

Emergency Contact Person _____ Phone _____

Person Responsible for Account _____ Phone _____

Email address: _____ Cell Phone # _____

Contact Preference 1, 2, 3 Home___ Cell ____ Work____ E-Mail____ Text____

Insurance Information:

Subscriber's Name _____ Subscriber's Birthdate _____

Subscriber's Employer _____

Name of Carrier _____ Group # _____

Subscriber's Social Security # _____ ID # _____

Patient's Relationship to Subscriber: _____Self _____Spouse _____ Child

Are you covered by an additional plan? _____Yes _____No

Name of Additional Carrier _____

How did you hear about us? _____ Friend/Relative _____ Yellow Pages _____ Web Site ____ Sign/Walk By

Referred by (Name) _____

HAVE YOU THOUGHT ABOUT CHANGING THE APPEARANCE OF YOUR SMILE?

If I could, I would change:

The alignment of my teeth _____ Yes ____ No

-Gaps/spaces

-Crowding

-Overbite/underbite

The color/shade of my teeth _____ Yes ____ No

Old silver fillings changed to tooth color _____ Yes ____ No

Other, please specify: _____

WE WOULD LIKE TO GET TO KNOW YOU BETTER

1. Have you seen a medical doctor during the past two years? _____Yes _____ No
   Please specify condition or treatment: _____
2. Are you currently taking any medicine or drugs? _____Yes _____ No
   (including over the counter medicines/herbal remedies)? Please specify: _____
   _____
3. Are you allergic to or made sick by any medications? _____Yes _____ No
   (Such as penicillin, codeine, or aspirin) Please specify: _____
4. Have you ever had a reaction to local anesthetic or other dental agents? _____Yes _____ No
5. Do you smoke, chew tobacco, and/or consume alcohol? *(circle)* _____Yes _____ No
   Amount : _____ Day _____ Week _____ How Often?
6. Do you use Marijuana medically/recreationally? _____Yes _____ No
   Amount : _____ Day _____ Week _____ How Often?
7. WOMEN: Are you taking birth control pills? _____Yes _____ No
   Are you pregnant? _____Yes _____ No
   (It is very important to inform us if you become pregnant).
8. Have you ever been told you occasionally snore? _____Yes _____ No
9. Has anyone ever noticed that you stop breathing while sleeping? _____Yes _____ No
10. Have you ever been diagnosed with sleep apnea? _____Yes _____ No
11. Have you ever taken Osteoporosis medications? (bisphosphonate) _____Yes _____ No
12. Name of Physician _____ City _____ Phone _____
13. Circle any of the following which you have had or have at present:

AIDS or HIV+	Diabetes	Kidney Trouble
Allergies or Hives	Epilepsy or Seizures	Liver Disease
Anemia	Fainting or Dizzy Spells	Migraine Headaches
Artificial Heart Valve	Glaucoma	Pain in Jaw Joints
Artificial Joint	Heart Disease or Attack	Radiation of jaw
Asthma	Heart Pacemaker	Sinus Trouble
Cancer	Heart Surgery	Stroke
Chemotherapy	Hemophilia (Prolonged Bleeding)	Substance Abuse
Cold Sores	Hepatitis A (infection)	Thyroid Disease
Congenital Heart Malformations	Hepatitis B (serum)	Tuberculosis
Consistent Headaches	Hepatitis C	Other: _____
Cortisone Medicine	High Blood Pressure	

TO THE BEST OF MY KNOWLEDGE, ALL OF THESE ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGES IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM ROOSEVELT DENTAL CENTER AT, OR BEFORE, MY NEXT APPOINTMENT.

We reserve the right to charge $75 for appointments canceled or broken without 24 hours advance notice.

_____ _____

Date Signature of patient, parent, or guardian

Health Updates

Date	Addition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____