Sammamish Family Dental
Robert L. Humble, DDS

Patient Information

Legal name: _____ Preferred Name: _____
Full address: _____
Home ph. #: _____ Work #: _____ Cell #: _____
E-mail: _____ Birthdate: _____ Social Security #: _____
Emergency contact?_____ Relation:_____ Ph. #:_____
Whom may we thank for recommending us? _____

Account Information

Person responsible for account:_____ Relation: _____
Home ph. #: _____ Work #: _____ Cell #: _____
Address: □-same as patient _____

Primary dental insurance company: _____
Employer:_____Group #: _____

Subscriber: _____I.D. or S.S. #: _____ Birthdate: _____

Secondary dental insurance company: _____
Employer: _____Group #: _____
Subscriber: _____I.D. or S.S. #: _____ Birthdate: _____

Updates (please review front and back of form)

Have there been any changes in contact info, insurance or health? Date:_____ □-No □-Yes:

_____

Have there been any changes in contact info, insurance or health? Date:_____ □-No □-Yes:

_____

Have there been any changes in contact info, insurance or health? Date:_____ □-No □-Yes:

_____

Medical History

Name of physician: _____Phone number: _____
Are you taking any over-the-counter medications or prescription drugs? □-No □-Yes:
Please list each with dosage: _____
_____
Do you smoke? □-No □-Yes: what and how much? _____
Women: Are you pregnant? □-No □-Yes: how many weeks? _____
Are you taking oral contraceptives? □-No □-Yes

Are you allergic to any of the following?

Y N Local anesthetic (Novocain) **Y N** Codeine **Y N** Metals
Y N Penicillin or other antibiotics **Y N** Aspirin **Y N** Latex

Do you have or have you ever had any of the following medical conditions or procedures?

Y N Prosthetic heart valves **Y N** Prosthetic joints **Y N** Diabetes
Y N Heart attack, angina, stroke **Y N** High Blood Pressure **Y N** Low Blood Pressure
Y N Fainting spells, seizures, epilepsy **Y N** Asthma **Y N** HIV-positive or AIDS
Y N Hepatitis **Y N** Cancer **Y N** Blood disorder
Is there any other medical information you'd like us to know? _____
_____

Dental History

Previous dentist, city:_____ Last exam:_____
Are you apprehensive about dental visits? **Y N** Do you usually use laughing gas? **Y N**
How often do you: brush your teeth? _____ floss?_____
Have you been told you have gum disease? **Y N** Do your gums bleed readily? **Y N**
Do your gums ever feel irritated, tender, or swollen? **Y N**
Are any of your teeth sensitive to: **Y N** heat, **Y N** cold, **Y N** sweets, **Y N** chewing
Do you grind your teeth or clench your jaw? **Y N**
Do you get cold sores (fever blisters) **Y N**
Does your jaw ever pop, lock open/closed, or do you have tenderness in the jaw area? **Y N**
What, if anything, about your smile would you like to improve? _____

Any specific interests, concerns or additional comments?_____
_____

To the best of my knowledge the above personal, medical, and dental information is correct:

Signature of patient/guardian: _____**Date:**_____