Hu Smiles in Renton

Welcome to our office. We appreciate the confidence you place with us to provide dental services to you. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please let us know. If you have any questions at all, please don't hesitate to ask. Thank you.

Patient Name: _____Date of birth: _____Sex: _____Age:_____

Home address: _____City: _____State: _____Zip:_____

Billing address (if different): _____City: _____State: _____Zip: _____

Home#: _____Cell: _____Work: _____Email:_____

SS#_____ Employer/Occupation: _____

Spouses name: _____Phone number: _____

Emergency contact (other than spouse): _____Phone number: _____

Name of Medical Doctor: _____Date of last visit: _____

Referred to us by: _____

Dental Primary Insurance: _____ ID#: _____ Group#: _____

Subscriber Name: _____ Date of birth: _____ SS#: _____

Dental Secondary Insurance: _____ID#:_____Group #: _____

Subscriber Name: _____ Date of birth: _____ SS#: _____

Dental Health History

	YES	NO		YES	NO
Are you apprehensive about dental treatment?	☐	☐	How often do you brush?_____		
Have you had problems with previous dental treatment?	☐	☐	How often do you floss?_____		
Do you gag Easily?	☐	☐	Does your jaw make noise that bothers you or others?	☐	☐
Do you wear dentures?	☐	☐	Do you clench or grind your jaws frequently?	☐	☐
Does food catch between your teeth?	☐	☐	Do your jaws ever feel tired?	☐	☐
Do you have difficulty in chewing food?	☐	☐	Does your jaw get stuck so that you can't open freely?	☐	☐
Do you avoid brushing any part of your mouth due to pain?	☐	☐	Does it hurt when you chew or open wide to take a bite?	☐	☐
Do your gums bleed easily?	☐	☐	Do you have earaches or pain in front of the ears?	☐	☐
Do your gums bleed when you floss?	☐	☐	Do you have any:		
Do your gums feel swollen or tender?	☐	☐	jaw symptoms/headaches upon waking up?	☐	☐
Have you noticed slow-healing sores in or about your mouth?	☐	☐	face, cheeks, jaws, joints, throat or temples?	☐	☐
Are your teeth sensative?	☐	☐	Does jaw pain or discomfort affect your:		
Do you feel twinges of pain when you are in contact with:			appetite sleep, daily routine or other activities?	☐	☐
Hot foods or liquid?	☐	☐	Do you take medications or pills for pain or discomfort?	☐	☐
Cold food or liquids?	☐	☐	Pain relievers, muscle relaxants, antidepressants?	☐	☐
Sours?	☐	☐	Do you have temporomandibular disorder?	☐	☐
Sweets?	☐	☐			