SPANAWAY
DENTAL WELLNESS

patient registration

PATIENT INFORMATION

Name____ Birthdate____________ SSN______________

Address____ City ___________________ State______ Zip______________

Email__________________________________ Home Phone_________________ Wireless Phone____________________

Occupation__________________________________ Student Status of dependent over 19 (for ins): ○Full Time ○Part Time

Do you allow appointment reminders sent to you via email? ○Yes ○No Sex: ○Female ○Male
Do you allow appointment reminders sent to you via mobile text? ○Yes ○No Status: ○Minor ○Single ○Married ○Divorced ○Widowed

Spouse or Parent/Guardian's Name _______________________________ Employer________________________________

Emergency Contact_______________________________ Relationship ___________________ Phone_________________

How did you hear about us? (please be specific)____

RESPONSIBLE PARTY

Name of person responsible for this account_________________________________ Relationship to Patient___________

Address (if diff. from above)____________________________________ City _______________ State_____ Zip_________

Email__________________________________ Home Phone_________________ Wireless Phone____________________

Employer_________________________________ Birthdate______________ Driver's License #____________________

Is this person currently a patient at our office? ○No ○Yes

PRIMARY DENTAL INSURANCE

Subscriber Name____________________________________ Relationship to Subscriber ○Self ○Spouse ○Child ○Other

Insurance Co.________________________ Subscriber Birthdate_____________ Group # ___________ ID# ___________

Employer______________________________ Insurance Phone_______________ If Military, E Status________________

Employer's Address ____ City _______________ State_____ Zip_________

Remaining Benefits: $___________ Remaining Deductible: $____________ *Please present insurance card to receptionist*

SECONDARY DENTAL INSURANCE

Subscriber Name____________________________________ Relationship to Subscriber ○Self ○Spouse ○Child ○Other

Insurance Co.________________________ Subscriber Birthdate_____________ Group # ___________ ID# ___________

Employer______________________________ Insurance Phone_______________ If Military, E Status________________

Employer's Address ____ City _______________ State_____ Zip_________

Remaining Benefits: $___________ Remaining Deductible: $____________ *Please present insurance card to receptionist*

Authorization and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company(ies) and assign directly to Spanaway Dental Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions whether manual or electronic. Spanaway Dental Wellness may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services.

_______________________________________ _______________________________________ _______________

Signature of patient (or parent/guardian if minor) **Print Name** of patient (or parent/guardian if minor) **Date**

SPANAWAY
DENTAL WELLNESS

medical & dental history

Name______________________________________ Birthdate: _____________ Today's Date: _____________

Physician________________________ Office Name________________________ Office Phone____________

CURRENT MEDICATIONS	ALLERGIES
____________________ ____________________ ____________________ ____________________ ____________________ ____________________	O Acetaminophen O Aspirin O Barbiturates, Sedatives O Codeine O Ibuprofen O Iodine O Local Anesthetic O Latex Rubber O Metals O Penicillin O Sulfa Drugs O Other________________

MEDICAL CONDITIONS

Y N
O O Rheumatic Heart Disease or Fever
O O Heart Murmur
O O Stroke
O O Heart Condition
O O Cardiac Pacemaker
O O Heart Attack
O O Artificial Heart Valve
O O Previous Infective Endocarditis
O O Damaged Valves in Transplanted Heart
Congenital Heart Disease (CHD):
O O Unrepaired, Cyanotic CHD
O O Repaired (completely) w/in last 6 mo.
O O Repaired CHD w/ residual defect

Y N
O O Anemia
O O Prolonged Bleeding
O O High Blood Pressure
O O High Cholesterol
O O Diabetes
O O Hemophilia
O O Sinus Problems
O O Asthma
O O COPD (Bronchitis, Emphysema)
O O Active Tuberculosis
O O Fainting Spells or Seizures
O O Hepatitis, Jaundice, or Liver Disease
O O Digestive Disorder

Y N
O O Acid Reflux, GERD, Heartburn
O O Kidney Disease
O O Thyroid or Parathyroid Disease
O O Arthritis
O O Head/Neck Injury
O O Joint Replacement
O O Osteoporosis or other Bone Conditions
O O Sexually Transmitted Disease
O O AIDS/HIV Infection
O O Autoimmune Disease
O O Cancer/Abnormal Tumor Growth
O O Psychiatric Treatments

Y N
O O Have you ever taken Phen-Phen/Redux?
O O Have you ever taken Fosamax, Actonel, Boniva, Aredia, Zometa or any other bisphosphonates?
O O Do you use tobacco? If so, how much/day:____________
Women Only:
O O Are you pregnant or nursing?
O O Are you taking oral contraceptives?

Y N **Sleep Disorder Screening Questionnaire**
O O Do you snore loudly?
O O Do you often feel tired, fatigued or sleep during the day?
O O Has anyone observed you stop breathing during your sleep?
O O Do you have or are you being treated for high BP?
O O Are you obese or very overweight (BMI > 35kg/m2)?
O O Are you 50 years old or older?
O O Is your neck circumference >16" (female) >17" (male)?
O O Are you male?

PREVIOUS DENTAL EXPERIENCE

I am changing dentists because: (check any that apply)
O Recently moved into this area from ____________
O Doctor/staff personality
O Communication problems
O Inadequate care
O Fee concerns
O Insurance
O Less Convenient Location
O Need a 2nd opinion
Former DDS:______________

I've avoided past dental care because: (check any that apply)
O Dental anxiety
O Previous treatment problems
O Trust factor
O Financial commitment
O Time commitment
O No perceived need

DENTAL CONCERNS

Y N
O O Teeth sensitivity
O O Dry mouth
O O Difficulty getting numb
O O Bleeding gums

Y N
O O Loose Teeth
O O Teeth grinding/clenching
O O Jaw pain/discomfort
O O Frequent headaches

O O Are you in dental pain?
O O Do you have a panoramic or full mouth x-rays < 5 years old?
O O Do you have bitewing x-rays that are less than 1 year old?

Date of last cleaning/exam: ____________________

I am interested in exploring: (check any that apply)
O Oral Sedation (pill) & nitrous gas options
O IV Sedations or General Anesthesia
O Sleep Apnea or Snoring Treatment Options
O Smile Makeover (Smile Analysis & Design)
O Ways to reduce or eliminate periodontal surgery (lasers)
O Implant Treatment
O Orthodontic Treatment (braces or clear aligner trays)
O "Gummy" or Gum Recession Treatment
O In-Office Whitening Treatment

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to dental examination and any necessary records that are necessary for an accurate diagnosis. I authorize the dentist to use any treatment records, x-rays, models or photos for scientific, teaching or promotional purposes.

______________________________ ______________________________ ____________
Signature of patient (or parent/guardian if minor) **Print Name** of patient (or parent/guardian if minor) **Date**