**150 Factoria Family Dentistry**
4100 Factoria Blvd SE #D Bellevue, WA
Bellevue, WA 98006
Ph # : 425-747-8888

FACTORIA FAMILY DENTISTRY

## Patient Personal Information

| | | | | | |
|---|---|---|---|---|---|
| Title | | Preferred Name | | Birth Date | Age |
| Last, First | | | | Marital Status | Sex |
| Address | | | | Home # | Work # |
| | | | | Cell # | Drive Lic |
| City, State, Zip | | | | Emergency Contact | Emergency Phone # |
| Email | | | | Student | SSN |
| Health Care Guardian Name | | | | School Name | |
| Health Care Guardian Phone # | | | | Referral Type | |

## Person responsible/guarantor for paying bills

| | | | | | |
|---|---|---|---|---|---|
| Title | | Preferred Name | | Birth Date | Age |
| Last, First | | | | Marital Status | Sex |
| Address | | | | Home # | Work # |
| | | | | Cell # | Drive Lic |
| City, State, Zip | | | | SSN | |
| Email | | | | | |

| Do you have Primary Dental Insurance? __ Yes __ No | | | | Do you have Secondary Dental Insurance? __ Yes __ No | | | |
|---|---|---|---|---|---|---|---|
| Group No/Name | | | | Group No/Name | | | |
| Insurance Name | | | | Insurance Name | | | |
| Phone # | | | | Phone # | | | |
| Employer Name | | | | Employer Name | | | |
| Subscriber Last, First | | | | Subscriber Last, First | | | |
| Subscriber Address | | | | Subscriber Address | | | |
| City, State, Zip | | | | City, State, Zip | | | |
| Relationship to Patient | | Birth Date | | Relationship to Patient | | Birth Date | |
| Subscriber ID | | | | Subscriber ID | | | |

## Patient Medical Information

**Existing Patients:**

**Allergic To**

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Amoxicillin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other Allergies
- ☐ Y ☐ N No Known Allergies

**Check, if applicable**

- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Bulimia
- ☐ Y ☐ N COPD
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy/Radiation
- ☐ Y ☐ N Chronic Pain
- ☐ Y ☐ N Congenital Heart Defect
- ☐ Y ☐ N Congestive Heart Failure
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Blood disease
- ☐ Y ☐ N Blood thinners
- ☐ Y ☐ N Osteopenia/Osteoporosis
- ☐ Y ☐ N Kidney disease
- ☐ Y ☐ N Hives
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Leukemia
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Skin Rash
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke/TIA
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss
- ☐ Y ☐ N Urinate Frequently

**Other**

- ☐ Y ☐ N AFib
- ☐ Y ☐ N High Cholesterol
- ☐ Y ☐ N Special Needs
- ☐ Y ☐ N Autism Spectrum Disorder (ASD)
- ☐ Y ☐ N Parkinson's Disease

☐ Y ☐ N Premedicate Prior To Dental Tx
☐ Y ☐ N Joint Replacement
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N Anemia
☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Environmental Allergies
☐ Y ☐ N Epilepsy
☐ Y ☐ N Fainting Spells
☐ Y ☐ N Fever Blisters
☐ Y ☐ N Frequent Headaches
☐ Y ☐ N Frequently Dry Mouth / Sjogren
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lupus
☐ Y ☐ N Mental Health Problems
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Seizures
☐ Y ☐ N Sleep Apnea Appliance
☐ Y ☐ N Artificial Heart Valve

**Additional Comments**

## Dental Questionnaire

**Dental Questionnaire**

If you are required to take a pre-medication prior to receiving dental treatment please list here. _____

Date of your last cleaning _____

Do you chew/smoke tobacco in any form ? _____

Are you having any specific problems with your teeth, gums, or mouth at this time ? _____

Do you use an electric toothbrush? _____

Do you use a WaterPik? _____

Do you wear a night guard at night? _____

**Additional Comments**

Any Disease, Condition or Problem not Listed ? Please list _____

## Medical Questionnaire

**Emergency Contact**

Emergency contact name _____

Emergency contact phone _____

Emergency contact relationship to patient _____

City / State / Zip _____

**Medical Questionnaire**

Family Physician _____

Phone _____

Have you had any serious illness, operation or been hospitalized within the past 5 years ? _____

If Yes, what illness or problem ? _____

Are you currently taking any medication ? _____

If Yes, please list all medications-prescription and over-the-counter: _____

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) _____

Have you ever taken the diet control drug Fen-Phen ? _____

On average, how many alcoholic beverages do you consume in a week ? _____

| | |
|---|---|
| Do you smoke? | |
| **Women Only** | |
| Do you have menstrual period problems ? | |
| Are you on hormone replacement therapy ? | |
| Are you on birth control pills / fertility drugs ? | |
| Are you pregnant? | |
| If Yes, what is your due date ? | |
| Are you currently nursing ? | |
| **Additional Comments** | |
| Please elaborate to any items marked "yes"? | |
| Any Disease, Condition or Problem not Listed ? Please list | |
| **Additional** | |
| Have you had joint replacement surgery? | |
| Have you ever had a heart attack, stent placement, or a heart valve replaced? | |
| Have you ever had a seizure or been diagnosed with a seizure disorder? | |
| Are you taking blood thinners? | |

By signing below, I certify that all of the above information is true to the best of my knowledge.

**Patient/Guardian Signature** **Date**

**Dentist Signature** **Date**