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Seattle, WA 98122

MADRONA FAMILY DENTAL
LOREN A. TARR, DDS, PLLC

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Thank you for choosing our office. We look forward to providing you with exceptional oral health care. Please answer all questions on all pages. If you are filling this out on your computer you can send the form electronically by clicking on the SUBMIT button at the bottom.

PATIENT NAME_____ PREFERRED NAME_____

❑male ❑female ❑transgender ❑non-binary Preferred pronouns: ❑he,him,his ❑she,her,hers ❑they,them,theirs

Social Security #_____ Date of Birth:_____

Mailing address:_____ City:_____ State:____ Zip code:_____

Email address:_____ Home phone No. (___)_____

Cell phone No. (___)_____ Work phone No. (___)_____ May we text you? ❑Yes ❑No

What is your preferred contact method? ❑Email ❑Home phone ❑Cell phone ❑Work phone ❑Text msg

Preferred appointment days: ❑Mon ❑Tue ❑Wed ❑Thu Preferred time: ❑early or ❑late AM ❑early or ❑late PM

❑Single ❑Married ❑Partnered ❑Divorced ❑Separated ❑Widowed

Patient Occupation_____ Employer_____ Work Phone (____)_____

Name of Spouse_____ Birthdate____/____/____ SSN_____

Spouse Occupation_____ Employer_____ Work Phone (____)_____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (Other than someone living with you)

Name_____ Home Ph. No. (____)_____ Work Ph. No. (____)_____

Relationship to patient_____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

Payment Is Expected At Time Of Each Visit

Please Check Method of Payment

❑ Cash ❑ Check ❑ Bankcard

Person responsible for payment: _____

Primary Dental Insurance

Employee_____

Relationship to Patient_____

Employer_____

Insurance Co._____ Group#_____

Insurance Phone No._____

Alt id or SSN_____

Subscriber D.O.B._____

Secondary Dental Insurance

Employee_____

Relationship to Patient_____

Employer_____

Insurance Co._____ Group#_____

Insurance Phone No._____

Alt id or SSN_____

Subscriber D.O.B._____

I have read and understand the Madrona Family Dental HIPPA Notices of Privacy Act.

Signature:_____ Date:_____

Are you having any pain or discomfort at this time? ❑ Yes ❑ No
Are you nervous about having dental treatment? ❑ Yes ❑ No
Have you ever had a bad dental experience? ❑ Yes ❑ No
Do you experience difficulty or pain when chewing, talking or using your jaw? ❑ Yes ❑ No
Do you have noises in your jaw joint? ❑ Yes ❑ No
Does your bite feel uncomfortable or unusual? ❑ Yes ❑ No
Have you ever had an injury to your head or jaw? ❑ Yes ❑ No
Have you been treated for a jaw joint problem? ❑ Yes ❑ No
Chief dental concern:_____

Do you have dry mouth? ❑ Yes ❑ No
Do your teeth ever feel loose? ❑ Yes ❑ No
Does food often catch in-between your teeth? ❑ Yes ❑ No
Do your gums bleed? ❑ Yes ❑ No
Have you ever had periodontal (gum) disease? ❑ Yes ❑ No
Are your teeth sensitive to cold/heat/sweets? ❑ Yes ❑ No
Do you take antibiotics for a health condition before each dental visit? ❑ Yes ❑ No
Previous Dentist and date of last visit:_____
Are you happy with the way your smile looks? ❑ Yes ❑ No
If not, what would you change?_____

Health History

Do you smoke or use chewing tobacco (please circle one) ❑ Yes ❑ No
Have you been hospitalized or had any surgeries in the past 2 years? ❑ Yes ❑ No
*If so, for what condition?*_____
WOMEN: Are you pregnant or nursing? ❑ Yes ❑ No
Do you have a personal Physician? ❑ Yes ❑ No
*Physician's Name:*_____
*Date of last visit:*_____
*Reason for visit:*_____

Are you currently taking any prescriptions, over the counter drugs or herbal supplements? ❑ Yes ❑ No
If so, please list and include the reason for taking:
_____
_____
_____

Have you ever taken Fosamax or any bisphosphonate for bone density issues/osteoporosis? ❑ Yes ❑ No
Please list any serious medical condition(s) that you currently have or have had in the past:_____
_____

Have you ever been diagnosed with sleep apnea? ❑ Yes ❑ No
Are you aware of or been told that you snore? ❑ Yes ❑ No
Do you generally feel well rested? ❑ Yes ❑ No
How many hours of sleep do you typically get each night?_____

Please Check any of the following which you have now or have had in the past.

❑ No medical conditions
❑ Angina Pectoris (Chest Pain)
❑ Heart Disease/Attack/Stroke
❑ Heart Failure
❑ High/Low Blood Pressure
❑ Congenital Heart Defect
❑ Heart murmur/Rheumatic Fever
❑ Heart Surgery
❑ Heart Pacemaker
❑ Artificial Heart Valve
❑ Diabetes, Type I ❑ II ❑
❑ Blood Transfusion/Anemia
❑ Sickle Cell Disease
❑ Bruise Easily
❑ Hemophilia/Blood Disorder
❑ Liver Disease/Yellow Jaundice
❑ Kidney Failure/Dysfunction
❑ Thyroid Disease/Condition
❑ Ulcers
❑ Glaucoma
❑ Cosmetic surgery_____
❑ Chemotherapy for Cancer
❑ X-ray Treatment for Cancer
❑ Tuberculoses (TB)
❑ Arthritis/Rheumatism/Lupus
❑ Cortisone Medicine/Steroids
❑ Sexually transmitted infection
❑ A.I.D.S./H.I.V.
❑ Hepatitis: A, B, C
❑ Frequent Headaches
❑ Artificial Joints (Hip, Knee, etc.)
❑ Canker Sores/Cold Sores
❑ Fainting/Dizzy Spells
❑ Epilepsy/ Seizures
❑ Hay Fever/Sinus Trouble
❑ Allergies/Hives
❑ Shingles
❑ Anxiety disorder
❑ Psychiatric Treatment
❑ Drug/Alcohol Addiction
❑ Emphysema/Asthma
❑ Depressed Immune System
❑ Organ Transplant
❑ Osteoporosis
❑ Other_____
❑ Barriatric surgery

Are you allergic to or have you reacted adversely to any of the following?

Please check any that apply.

❑ Aspirin ❑ Codeine ❑ Demerol ❑ Percocet/dan ❑ Valium ❑ Sulfa ❑ Nitrous Oxide ❑ Penicillin ❑ Erythromycin ❑ Tetracycline ❑ Other Antibiotics ❑ Latex ❑ Metals/Jewelry ❑ Local Anesthetic

*List any other allergies here:*_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover.

Patient Signature_____ **Date**_____

Doctor Signature_____ **Date**_____

Update Record

Date	Initial

SUBMIT

AHH 2/24/15