Patient Information

first mi last (preferred name) | home phone | cell phone | email address

address | city | state | zip

birthdate | SSN | driver's license # | spouse

employer | employer's address | business phone

Emergency contact name and phone number | Physician name and phone number

Insurance Information

insurance | group # | id #

address | city state zip | phone #

Medical History

Are you in good health?	Yes	No
Are you under the care of a physician?	Yes	No
Have you ever had a serious illness or operation?	Yes	No
Are you taking any drugs or medications?	Yes	No
Are you allergic to any drugs or medications?	Yes	No
Have you ever had trouble with heart surgery?	Yes	No
Do you have any prosthetic joints or pins?	Yes	No
Are you pregnant?	Yes	No

Dental History

Any unfavorable reactions to local anesthetic?	Yes	No
Any unpleasant dental experiences?	Yes	No
Do you use tobacco?	Yes	No
Do you have difficulty opening your mouth?	Yes	No
Was your last cleaning more than 6 months ago?	Yes	No
Are you happy with your smile?	Yes	No

HOW DID YOU HEAR ABOUT US?_____

Do you have (or have you had) any of the following: (please circle)

AIDS/HIV	Addictions	Hepatitis or Liver Problems	Stroke
Allergies	Epilepsy or Seizures	Herpes or Cold Sores	Stomach Ulcers
Anemia	Excessive Bleeding	H/L Blood Pressure	STD's
Arthritis	Heart Murmurs	Kidney Disease	Tuberculosis
Asthma or Hay Fever	Facial Injuries	Latex Allergy	List Medications/Allergies
Cancer or Tumor	Mental Disorders	Respiratory Disease	_____
Diabetes	Nervous Disorders	Rheumatic Fever	_____

Consent for Treatment

I authorize Guy F. Roberts, DDS and staff to administer dental treatment as deemed necessary or advisable in the diagnosis and treatment of the person listed and assume financial responsibility for those services. I acknowledge that the above information is complete and correct.

Patient or Guardian Signature | Date

GUY F. ROBERTS DDS, 500 E HOWELL ST, SEATTLE WA 98122