Bellevue Westlake Dental
General Dentistry

1855 156th Ave NE #210, Bellevue, WA 98007 (425) 747-8340 Email: info@bellevuewestlakedental.com

Adult Registration and Health History

Name _____ Preferred Name _____

Mailing Address _____

Street City State Zip

Home Phone _____ Mobile Phone _____ Work Phone _____

Can your mobile phone be used for text messaging? Yes ___ No ___

Social Security # _____ Birth Date _____ Email _____

Name of Spouse _____ Birth Date _____ Phone _____

Employer _____ Spouse's Employer _____

Emergency Contact: Name _____ Phone _____

Dental Insurance Company

Primary Dental Insurance Company

Name _____ Group # _____ Phone _____

Subscribers Name _____ Date of Birth _____ ID# _____

Secondary Dental Insurance Company

Name _____ Group # _____ Phone _____

Subscribers Name _____ Date of Birth _____ ID# _____

Medical History

Physician's Name _____ Phone _____ Last Examination _____

Women: Are you Pregnant? Yes __ No __ OB Name _____Phone _____

Have you had a history of (check all that apply)

Heart Murmur ____
Heart Attack ____
Heart Surgery ____
Other Heart Problems ____
Pacemaker ___ Date _____
Developmental Disabilities ____
Breathing Difficulty ____
Asthma ____
Joint Replacement ____ Date _____
Hepatitis A___ B___C___D ___

High Blood Pressure ____
Low Blood Pressure ____
Epilepsy ____
Radiation Treatment ____
Bleeding Problems ____
Other Blood Problems ____
Fainting ____
AIDS/HIV ____
Liver Disease ____
Tuberculosis ____

Stroke ____
Rheumatic Fever ____
Hemophilia ____
Tuberculosis ____
Anemia ____
Diabetes ____
Cancer ____ Date _____
Kidney Problems ____
Multiple Sclerosis ____

Medications you are taking: (List on back if needed)

_____

Allergies to Medications, Latex, Other: Please List _____

Do you take medication for Osteoporosis? Yes ___ No ___ Medication _____

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Dental History

Previous Dentist _____ Phone _____ Do you have x-rays to transfer? ____
Date of last x-rays _____ Date of last dental examination _____
Purpose of today's visit _____
Have you been premedicated for dental treatment in the past? _____ Reason _____
Do you use tobacco? _____ Type _____ How often _____ Can you stop _____
Do you have any chronic dental problems? _____
Have you ever been told you have periodontal disease? _____ Treatment _____
Are you happy with the appearance of your teeth? _____
Do you have any problems with your jaw (TMJ) _____
How often do you brush? _____ Floss _____ Other _____
Is there anything you would like me to know regarding your treatment? _____
Who may we thank for referring you? _____
Describe current dental problems or concerns:

Signature _____ **Date** _____

List of additional Medications:

	Drug	Dose	Purpose of Drug
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			