Bellevue Dental Care & Implant Center

John B. Minnoch DDS

900 108th Ave. NE Suite 102
Bellevue, WA 98004
P: 425.709.7171
F: 425.709.7197

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?
☐ Trying to get Pregnant?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Patient's General Information

Patient's Name : _____ **Date of Birth :** _____/_____/_____

If patient is minor, responsible party : _____ **Phone :** _____

Home Address : _____ **Apt :**_____ **City :** _____ **Zip :** _____

Home # : _____ **Wk # :** _____ **Cell # :** _____

Employer : _____ **Occupation :** _____ **Employer Address :** _____

Email : _____@_____

Status : MINOR SINGLE MARRIED LONG TERM PARTNER DIVORCED WIDOWED SEPARATED

Emergency Contact Name : _____ **Relation :** _____ **Phone # :** _____

How did you hear about us / referred by? Name _____**Insurance Co.** __**Dentist** __ **Web Site** _____
Other : _____

Insurance Information

Primary: Insurance Company Name / Phone

_____

_____

Insured Employer: _____
Insured Soc Sec #: _____
Group Number: _____

Secondary: Insurance Company Name / Phone:

_____

_____

Insured Employer: _____
Insured Soc Sec #: _____
Group Number: _____

As a service to you, we will complete and file your insurance claim forms for completed treatment. Please remember that insurance plans are usually not designed to pay for everything. We urge you to read your policy. We will do our utmost to see that you receive maximum benefits within the structure of your insurance plan. Your portion of payment (the costs your insurance will not cover) is due at the time of service. Accepted forms of payment include: Cash/Check, Visa or MasterCard, or online by PayPal.

If you have no insurance, payment for service is due at the time of treatment. To assist you we offer the following options for payment: Cash/Check, Visa or MasterCard, or online by PayPal.

Financial Policy

We understand and appreciate your concerns regarding fees associated with treatment, and feel that you should have a clear understanding of your financial commitment for services provided. We will be happy to discuss fees anytime prior to treatment. As our patient, you should fully understand our mutual obligations and responsibilities.

In consideration of the required professional services provided to the above patient, I/we agree to pay the account for these services in full, at the time of service, unless prior arrangements have been made with Dr. Minnoch/Office Manager. A finance charge of 1.0% monthly will be added to my outstanding account balance after 30 days and 18% on balances over 120 days old.

By signing my name, I agree to this patient registration contract and acknowledge the financial policy. I also attest that all patient, spouse, health and dental information provided are accurate.

I authorize payment directly to Dr. Minnoch for all insurance benefits. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Cancellation Policy

When you make an appointment, we reserve time exclusively for you. Appointments cancelled with less than 48 hours notice are subject to a charge of $85 per hour.

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Signature of Responsible Party _____ **Date** _____

Oral health History

Previous Dental Office:_____ City, State_____

Previous Dental Office Phone number: (____)_____ Misc info _____

Date of last Dental visit? _____ X-ray taken? Y___ N___

Do you have to pre-medicate (take antibiotics) before dental treatment? Y___ N___

Does dental treatment make you nervous? Y___ N___ Explain: _____

Do you have, or have had, any of the following?

Y__ N__	Bleeding	Y__ N__	Sore Gums	Y__ N__	Burning tongue or lips
Y__ N__	Bad Breath	Y__ N__	Swollen Gums	Y__ N__	Frequent Blisters on lips
Y__ N__	Dry Mouth	Y__ N__	Loose Teeth	Y__ N__	Orthodontic Treatment
Y__ N__	Headaches	Y__ N__	Floss Catches	Y__ N__	Wisdom teeth removed
Y__ N__	Food Impaction	Y__ N__	Clenching	Y__ N__	Uncomfortable bite
Y__ N__	Grindng	Y__ N__	Head/Neck Injury	Y__ N__	Difficulty in jaw (Clicking/popping/pain)

Are you sensitive to: Hot____ Cold____ Sweets____ Biting____ Chewing____

If sensitive, where?_____

Do you have dental pain at this time? Y__ N__ Explain: _____

How often do you brush? _____ How often do you floss? _____

What type of brush do you use? _____ Soft__ Medium__ Hard__ Electric___

Are you satisfied with the appearance of your teeth? Y__ N__ What would you change?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my or patient's health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____DATE_____