U-District Family Dentistry . 4333 12th Avenue NE . Seattle, WA 98105
Andy Nelson, DDS . Roger L. Campbell, DDS

General Patient Information

Name (First, Middle, Last): _____ Today's Date: _____

Preferred Name: _____ Patient's Birthday: _____

Patient's SS#: _____ Sex: Male___ Female___ Occupation:_____

Marital Status (circle): Single | Married | Divorced Spouse/Partner Name if Applicable: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone#: _____ Cell Phone#: _____

Work Phone#: _____ E-mail: _____

What is the preferred way to contact you regarding appointments?: _____

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone#: _____

Has any member of your family ever been treated in our office?: _____

To whom may our office thank for referring you to U-District Family Dentistry:_____

Insurance Information

○ Please check here if you do not have dental insurance coverage.

Primary Insurance Information
(please have staff make a copy of your insurance card)

Subscriber Name: _____

Subscriber ID: _____

Date of Birth: _____

Subscriber SS#: _____

Employer: _____

Occupation: _____

Relationship to Insurance Subscriber:
Self / Spouse / Child / Other

Dental Insurance Company: _____

Phone: _____

Address: _____

Group #: _____

Secondary Insurance Information
(please have staff make a copy of your insurance card)

Subscriber Name: _____

Subscriber ID: _____

Date of Birth: _____

Subscriber SS#: _____

Employer: _____

Occupation: _____

Relationship to Insurance Subscriber:
Self / Spouse / Child / Other

Dental Insurance Company: _____

Phone: _____

Address: _____

Group #: _____

Insurance Disclaimer

I understand that my insurance is an agreement between me and my insurance company and that I am responsible for my balance regardless of my insurance. I assign dental benefit payments to be paid directly to Dr. Nelson & Dr. Campbell from my insurance company.

Patient's (Parent's) Signature: _____ Date: _____

Initial Treatment Consent

I give permission for my dentist and his/her clinical team to take any necessary x-rays, photos, or study models to enable complete diagnosis and treatment.

Patient's (Parent's) Signature: _____ Date: _____

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U·DISTRICT Family Dentistry

Dental History

please circle

Do you have a specific dental problem?	Yes No	Describe:_____
Do you have routine dental exams?	Yes No	Last Visit: _____
Do you think you have active decay or gum disease?	Yes No	
Do you brush and floss on a routine basis?	Yes No	
Do your gums ever bleed?	Yes No	
Is there any part of your smile that you want to improve?	Yes No	Describe: _____
Would you like the color of your teeth to be whiter?	Yes No	
Are there old fillings or dental work that you don't like?	Yes No	
Have you ever been treated for gum (periodontal) disease?	Yes No	
Do you ever have trouble with Halitosis (bad breath)?	Yes No	
Do you clench or grind your teeth during the day or night?	Yes No	
Have you ever had an unpleasant dental experience?	Yes No	

What is your chief concern or main goal(s) in getting dental treatment?_____

Medical History

Have you ever had any of the following? *(please circle)* Today's Date: _____

Heart Problems	Yes No	Asthma	Yes No	Stroke	Yes No
High Blood Pressure	Yes No	Epilepsy	Yes No	Ulcer	Yes No
Low Blood Pressure	Yes No	Headaches	Yes No	Venereal Disease	Yes No
Circulatory Problems	Yes No	Hepatitis or Jaundice	Yes No	Hemophilia	Yes No
Heart Murmurs	Yes No	Cancer	Yes No	Nervous Problems	Yes No
Radiation Treatment	Yes No	Respiratory Problems	Yes No	Excessive Bleeding	Yes No
Artificial heart valve	Yes No	Psychiatric Care	Yes No	Tuberculosis	Yes No
Artificial Joint	Yes No	Blood Disease	Yes No	Alcohol Addiction	Yes No
Anemia	Yes No	Arthritis	Yes No	Drug Addiction	Yes No
Phen/Fen	Yes No	Thyroid Disorder	Yes No	Diabetes	Yes No
Mitral Valve Prolapse	Yes No	Swollen Neck Glands	Yes No	Dizziness or Fainting	Yes No
Heart Surgery	Yes No	Recent Weight Loss	Yes No	Kidney Problems	Yes No
Rheumatic Fever	Yes No	Sinus Problems	Yes No	Cortisone Medicine	Yes No
Heart Pacemaker	Yes No	AIDS	Yes No	HIV Positive	Yes No

Primary Physician's Name: _____ Phone #: _____

Please Circle

Have you ever been hospitalized or had a major operation?	Yes No	Describe: _____
Have you ever had a serious injury to your head or neck?	Yes No	Describe: _____
Have you ever responded adversely to medical or dental treatment?	Yes No	
Do you smoke or chew tobacco?	Yes No	How often? _____
Do you have trouble breathing or snoring while sleeping?	Yes No	

Please list any medications, pills, or drugs that you are taking: _____

_____

Please check any medications or substances that you may be allergic to below:

Aspirin Penicillin Codeine Acrylic Metal Latex Other _____

Have you had any significant illness not checked above? Describe: _____

WOMEN (*please circle*): Pregnant/trying to get pregnant Nursing Taking Oral Contraceptives Menopause

Patient's or (Parent) Signature: _____ Reviewed by Dr.: _____

Medical Updates - I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

Date	Changes in Medical History		Patient Signature	Reviewed By
_____	_____	None	_____	_____
_____	_____	None	_____	_____
_____	_____	None	_____	_____
_____	_____	None	_____	_____
_____	_____	None	_____	_____

Acknowledgement of Receipt of Notice of Privacy Practices

Andy Nelson, DDS
Roger L. Campbell, DDS

- We keep a record of the health care services we provide you.
- We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

By my signature below I acknowledge receipt of the *Notice of Privacy Practices*.
** You may refuse to sign this acknowledgment.*

_____ _____
Patient or legally authorized individual signature Date

_____
Printed Name

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other *(please specify)*: _____