Welcome to
Sequim Family Dentistry

Dr. Brian Juel, DDS P.S.

Dr. Nathan Gelder, DMD

Today's Date________, 20___

PATIENT INFORMATION

Patient's Name____ Birth date___/___/______
Last First Middle

Address____________________________________ Home Phone______________ SSN_________
Street City State/Zip

If patient is a minor, give parent's or guardian's name___________________________________

Confidential Responsible Party / Adult Information

Name:_______________________________ I prefer to be called:____________ Male__ Female__
Last First MI

Birth date___/___/___ Age:___ Social Security #:______________________ S ( ) M( ) W( ) D( )

Home Address:_________________________________ How long atthis address:___________

Mailing Address (if different than above)____

Previous Address (if less than 2 years)_____________________________________(______)
Street City/State Zip How long

Home Phone #: (____)____________Work #:____________ Ext:_______ Pager/Cell#:__________

Driver License #:__________________ E-Mail Address:____________________________

When and where are the best times to reach you?____________________________________

Whom may we thank for referring you?____

Other family members seen by us?____

Employer__________________ No. Years Employed_________ Occupation______________

Employer Address____ Phone#__________

SPOUSE INFORMATION

Spouse's Name____________________________ Relationship to Patient_______________

Employer___________________ No. Years Employed________ Occupation______________

Social Security #______________ Birth date___/___/_____ Home/Work #________________

EMERGENCY INFORMATION

Name of nearest relative or friend not living with you_________________________________

Complete address____

Phone #_________________________Relationship___________________________________

INSURANCE INFORMATION

Primary Insurance

Insurance Company Name__________________________________ Phone #_______________

Group # (Plan, Local or Policy)______________________________

Insurance Company Address____

Insured's Name__________________ Social Security #___________ Insured Birth Date___/___/_____

Relationship to Patient_______________ Insured's Employer_______________________________

Insured's Employer Address______________________________ Employer's Phone #__________

Secondary Insurance

Insurance Company Name__________________________________ Phone #_______________

Group # (Plan, Local or Policy)______________________________

Insurance Company Address____

Insured's Name__________________ Social Security #___________ Insured Birth Date___/___/_____

Relationship to Patient_______________ Insured's Employer_______________________________

Insured's Employer Address______________________________ Employer's Phone #__________

(Over)

Sequim Family Dentistry

Why have you come to the dentist today? ____________________

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Have you experienced problems associated with any previous dental work? Yes No

Are you APPREHENSIVE about dental treatment? Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint(TMJ/TMD)? Yes No

Are you aware of GRINDING or CLENCHING your teeth? Yes No

Have you worn BRACES on your teeth (ORTHODONTICS) Yes No

Do you have dry mouth? Yes No

Do your gums BLEED, feel TENDER or are IRRITATED? *Circle One*

Have you ever had periodontal disease? Yes No

Do you have mobility in your teeth? Yes No

Are your teeth sensitive to heat, cold, or anything else? ____________

Previous/Present Dentist ____________ Last Visit Date ______

City & State ____________

Are you happy with the way your smile looks? Yes No

If not, what would you change? ____________

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment. (1 through 4, 1 being the most and 4 being the least)

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: ____________

Address: ____________

Street City State Zip

Phone #: (___)____________ Date of last visit: ____________

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

If yes, please explain: ____________

Has there been a change in your health within the last year? Yes No

Do you smoke or use tobacco in any other form? Yes No

Are you allergic to any of the following?

Y N Aspirin	**Y N Erythromycin**	**Y N Sedatives**
Y N Barbiturates	**Y N Jewelry/Metals**	**Y N Sulfa Drugs**
Y N Codeine	**Y N Latex**	**Y N Tetracycline**
Y N Anesthetics	**Y N Penicillin**	**Y N Nitrous Oxide**

Please list additional drugs/materials that cause allergic reactions:

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No

Week #: Are you nursing? Yes No

Please Circle "Yes" for the medications you are taking:

Y N Analgesics	Y N Blood Pressure Med.	Y N Nitroglycerin	Y N Tranquilizers
Y N Antibiotics	Y N Cold Remedies	Y N Recreational Drugs	
Y N Antihistamines	Y N Digitalis/Heart Med.	Y N Steroids/Cortisone	Y N Have you ever taken a diet drug called Fen-Phen?
Y N Blood Thinners	Y N Insulin/Diabetes Drugs	Y N Thyroid medicine	

Are you taking any prescription/over-the-counter drugs not listed above? Yes No **If yes, please list each one:**

Please Circle "Yes" to any of the following which apply:

Y N Abnormal Bleeding	Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Seizures
Y N Alcohol Abuse	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Shingles
Y N Anemia	Y N Congenital Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Angina Pectoris	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty swallowing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Osteoporosis	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis/A B C	Y N Pacemaker	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fever blisters	Y N HIV+/AIDS	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized(any reason)	Y N Scarlet Fever	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced:

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It 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 where appropriate, credit bureau reports may be obtained. A late fee of $25 may be incurred for monthly balances left unpaid.

Signature ____________ Date ______

I certify that I am covered by ____________ Insurance Co. and I assign benefits directly to Dr. Brian L. Juel D.D.S. , otherwise payable to me. I understand that I am responsible for payment of services rendered as well as any co-pays, deductibles or other services that my insurance does not cover. A late fee of $25 may be incurred for monthly balances left unpaid. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my submissions, whether manual or electronic.

Signature ____________ Date ______