

GABRIEL MALOUF, DDS

MODERN DENTISTRY • FAMILY VALUES

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Please answer all questions on **both** sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

PATIENT'S NAME _____ Preferred Name _____

Married Single Divorced Separated Widowed

Male Female Social Security No. _____ - _____ Birthdate _____ / _____ / _____

Mailing Address _____ Home Phone (____) _____ - _____

City _____ State _____ Zip Code _____

Cell (____) _____ - _____ Fax (____) _____ - _____ Email _____

How did you hear about our office?

Location Postcard Referral Card Office Website Hometown Values
 Phonebook Sno Valley Star Insurance Internet Other _____

Whom may we thank for referring you? _____

Name of Spouse _____ Birthdate _____ / _____ / _____ Social Security No. _____ - _____

Patient Occupation _____ Employer _____ Work Phone (____) _____ - _____

Spouse Occupation _____ Employer _____ Work Phone (____) _____ - _____

PRIMARY DENTAL INSURANCE

Employee _____
Employer _____
Insurance Co. _____ Group# _____
Employee's S.S. No. _____ - _____

SECONDARY DENTAL INSURANCE

Employee _____
Employer _____
Insurance Co. _____ Group# _____
Employee's S.S. No. _____ - _____

Person responsible for payment: _____

* * * * *

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Ph. No. (____) _____ - _____ Work Ph. No. (____) _____ - _____

Relationship to Patient _____

DENTAL HISTORY

Chief dental concern: _____

- Are you nervous about having dental treatment? Yes No
- Have you ever had a bad dental experience? Yes No
- Do you have difficulty or pain when opening (yawning)? Yes No
- Does your jaw get stuck, locked or "go out"? Yes No
- Difficulty / pain when chewing, talking, or using your jaws? Yes No
- Teeth? Yes No
- Do you have noises in your jaw joints? Yes No
- Pain about the ears, temples or cheeks? Yes No
- Does your bite feel uncomfortable or unusual? Yes No
- Have you had a recent injury to your head / jaw? Yes No

- Have you been treated for a jaw joint problem? Yes No
- Do your teeth ever feel loose? Yes No
- Does food catch in-between your teeth? Yes No
- How often do you brush? _____ Floss? _____ Yes No
- Any difficulty chewing your food? Yes No
- Have you ever had periodontal disease? Yes No
- Are your teeth sensitive to cold / heat / etc? Yes No
- Have you ever been premedicated for dental work? Yes No
- Do you have frequent Headaches? Yes No
- Are you happy with the way your smile looks? Yes No
- If not, what would you change? _____

HEALTH HISTORY

- Are you having any pain or discomfort at this time? Yes No
- Do you smoke or use tobacco in any form? Yes No
- Have you been hospitalized in the past 2 years? Yes No
- Have you been under the care of a medical doctor during the past 2 years? Yes No
- Physician Name _____
- Address _____ Phone: _____

- Are you currently taking any medications / drugs? Yes No
- If yes, please list: _____
- List Medications: _____
- _____
- _____
- Women: Are you pregnant? Yes No
- Please list any serious medical condition(s) that you have/had: _____

Please check "Yes or No" to the following conditions:

- | | | | |
|--|--|---|--|
| <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Angina Pectoris</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Disease / Attack / Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Failure</p> <p><input type="checkbox"/> <input type="checkbox"/> High / Low Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Murmur / Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Pacemaker</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Transfusion / Anemia</p> | <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Bruise Easily</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Disease / Yellow Jaundice</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Failure/Disfunction</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> Chemotherapy / Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> X-ray / Cobalt Treatment</p> <p><input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery</p> | <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema / Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Cough / Tuberculosis (TB)</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis / Rheumatism</p> <p><input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> A.I.D.S. / H.I.V.</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis: A B C (circle one)</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joint</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Joints (Hip, Knee)</p> <p><input type="checkbox"/> <input type="checkbox"/> Scarlet Fever</p> | <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever Blisters / Cold Sores</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting / Dizzy Spells</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Hay Fever / Sinus Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies / Hives</p> <p><input type="checkbox"/> <input type="checkbox"/> Shingles</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> <input type="checkbox"/> Psychiatric Treatment</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug / Alcohol Addiction</p> |
|--|--|---|--|

Are you allergic to or have you reacted adversely to the following?

- Antibiotics Aspirin
- Codeine Latex
- Metals / Jewelry Local/Dental Anesthetic

Are you aware of being allergic to any other medications or substances? If yes, please list:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also give permission to Dr. Gabriel Malouf and his staff to use any photos taken for lecturing and continuing education purposes.

Signature _____ Date _____

<i>Medical History Update</i> <small>(For Office Use Only)</small>			
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____