

Dr. Nina Svino
Aesthetic and Lifestyle Dentistry

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PERSONAL INFORMATION

Today's Date: _____
Patient Name: _____ Preferred Name (if any): _____
Age: ____ Birth date: _____ Social Security # _____
If minor, responsible party's name & relationship: _____
Male __ Female __ Marital Status: Single __ Married __ Widowed __ Divorced __ Separated __ Partner __
Home Address _____ e-mail Address: _____
City _____ State: _____ Zip Code: _____
Home Telephone: _____ Cell Phone: _____
Employed: Yes ____ No ____ Self ____ Name of Company: _____
City _____ Zip _____ Work Telephone: _____

Who may we thank for referring you to our office?

PRIMARY INSURANCE INFORMATION

Insured Individual's Name: _____
Relationship to Patient: _____ Birth date: _____
Employed by: _____ Insurance Company: _____
Insurance Company Address: _____
Subscriber ID/SS #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

Insured Individual's Name: _____
Relationship to Patient: _____ Birth date: _____
Employed by: _____ Insurance Company: _____
Insurance Company Address: _____
Subscriber ID/SS #: _____ Group #: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____
Phone number: _____ Cell number: _____

DENTAL HISTORY

1. Date of Last dental visit: _____ Previous Dentist: _____
2. Are you presently in pain? YES NO If yes, check all that apply ____Teeth __Gums __Jaws __Face
3. Is any part of your mouth sensitive? YES NO If yes, check all that apply ____ Hot __ Cold __ Sweet __ Pressure
4. Have you ever been informed that you have a gum problem? YES NO
5. Have you ever had periodontal treatment? YES NO
6. Are you aware of clenching or grinding your teeth? YES NO
7. Do you have pain in your jaw joints? (TMJ) YES NO
8. How often do you floss during the week? _____
9. Do you bleed when you floss or brush? YES NO
10. Have you ever had an unfavorable reaction to local anesthetic? YES NO
If yes, explain:
11. Have you ever been nervous with any previous dental treatment? __No __Slightly __ Moderately __ Extremely
12. Are you dissatisfied with the appearance of your teeth? YES NO
If yes, what would you like to change?

13. Are there any other comments regarding your smile, teeth, or facial characteristics?

HEALTH HISTORY

The following questions are associated with the proper management of your oral health.

1. Are you in good health? YES NO If no, what is the nature of your illness? _____
2. Date of your last physical examination: _____ Blood pressure: _____
3. Are you being treated by a physician now? YES NO Name of physician _____
If yes, what for? _____
4. Have you had excessive bleeding requiring special treatment? YES NO _____
If yes, describe: _____
5. Have you ever had any serious injury or surgery? YES NO _____
If yes, describe: _____
6. Do you have a cardiac pacemaker or any internal prosthetic device? YES NO _____
If yes, specify: _____
7. Have ever had radiation treatment or chemotherapy drugs? YES NO _____
If yes, specify: _____
8. Do you currently have any infectious disease including venereal disease? YES NO
9. Do you have any disease, condition or problem not listed above that you think the doctor should know about?
If so, please explain: _____
10. *Women Only:* Are you pregnant? YES NO If yes, what month? ____ Do you take birth control pills? YES NO
11. **Please list all drugs and medications you are taking:**

Have you ever had any of the following conditions?

Rheumatic Fever	Y or N	Respiratory Disorder	Y or N
Heart Disease/Attack	Y or N	Tuberculosis	Y or N
Heart Murmur	Y or N	Asthma	Y or N
Mitral Valve Prolapse	Y or N	Liver Disorder	Y or N
Stroke	Y or N	Kidney Disorder	Y or N
High/Low Blood Pressure	Y or N	Diabetes	Y or N
Anemia	Y or N	HIV (AIDS)	Y or N
Osteoporosis	Y or N	Hepatitis Type A/B/C	Y or N
Headaches/Migraines	Y or N	Cancer	Y or N
Epilepsy	Y or N	Arthritis	Y or N

Are you allergic to any of the following drugs?

Local Anesthetics	Y or N	Non-Steroidal Anti-Inflammatory Drugs	Y or N
Epinephrine	Y or N	Codeine or other narcotics	Y or N
Penicillin	Y or N	Other Pain Medications	Y or N
Sulfa	Y or N	Barbiturates, Sedatives, Sleeping Pills	Y or N
Other Antibiotics	Y or N	Iodine	Y or N
Aspirin	Y or N	Latex	Y or N
Any other drugs	Y or N	Please Specify _____	

Do you smoke? YES NO If yes, how much? _____

Do you drink alcohol? YES NO If yes, how much? _____

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release any and all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature

Date