

Bannerwood Family & Cosmetic Dentistry

Puneet Aulakh DDS

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PATIENT INFORMATION

First Name: _____ Preferred Name: _____
 Last Name: _____ Home Phone: _____
 Address: _____ Work Phone: _____
 City, State, Zip: _____ Cell Phone: _____
 Date of Birth: _____ Email: _____
 Emergency Contact & Phone: _____ SSN: _____
 Person Responsible for Account: _____

INSURANCE INFORMATION

Primary Insurance Co: _____ Policy Holder: _____ DOB: _____
 Employer: _____ Group #: _____ ID #/ SSN: _____
 Secondary Insurance: _____

DENTAL HISTORY

YES_NO	YES_NO
Are you apprehensive about dental treatment?..... [] []	How often do you brush? _____
Have you had problems with past dental treatment?.... [] []	How often do you floss? _____
Do you gag easily?..... [] []	Does your jaw make noise so that it bothers you
Do you wear dentures?..... [] []	or others?..... [] []
Does food catch between your teeth?..... [] []	Do you clench or grind your jaws frequently..... [] []
Do you chew on only one side of your mouth?..... [] []	Does your jaw get stuck so you can't open freely?..... [] []
Do you avoid brushing any part of your mouth	Does it hurt when you chew or open to take a bit?..... [] []
because of pain?..... [] []	Do you have earaches or pain in front of the ears?..... [] []
Do your gums bleed easily?..... [] []	Do you have any jaw symptoms or headaches upon
Do your gums bleed when you floss?..... [] []	waking in the morning?..... [] []
Do your gums feel swollen or tender?..... [] []	Does jaw pain or discomfort affect your appetite,
Have you ever noticed slow healing sores in or	sleep, daily routine, or other activities?..... [] []
About your mouth?..... [] []	Do you find jaw pain or discomfort extremely
Are your teeth sensitive?..... [] []	frustrating or depressing?..... [] []
Do you feel twinges of pain when you teeth come	Do you take medications or pills for pain or
in contact with:	discomfort (pain relievers, muscle relaxants)? [] []
Hot foods or liquids?..... [] []	Do you have a temporomandibular (jaw) disorder (TMJ) [] []
Cold foods or liquids?..... [] []	Do you have pain in the face, cheeks, jaws, joints
Sours?..... [] []	throat, or temples?..... [] []
Sweets?..... [] []	Are you unable to open your mouth as far
Do you take fluoride supplements?..... [] []	as you want?..... [] []
Are you dissatisfied with the appearance of your teeth [] []	Are you aware of an uncomfortable bite?..... [] []
Do you prefer to save your teeth?..... [] []	Have you had trauma to the jaw?..... [] []
Do you want complete dental care?..... [] []	Are you a habitual gum chewer or pipe smoker?..... [] []