THERON MANSON DDS PS
COSMETIC & FAMILY DENTISTRY
9750 NE 120th Pl., Ste. 8
Kirkland, WA 98034
425-823-1909

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

If This Appointment Is For You, Start Here			
DATE	NAME		
SOC. SEC #	BIRTHDATE		
SPOUSE			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE	CELL PHONE		
MARRIED ☐	SINGLE ☐	DIVORCED ☐	WIDOWED ☐
EMAIL ADDRESS			

If This Appointment Is For Your Child, Start Here		
DATE	NAME	
ADDRESS		
CITY	STATE	ZIP
HOME PHONE	CELL PHONE	
BIRTHDATE	AGE	GRADE
SCHOOL		

Dental Insurance		
PRIMARY CARRIER		
INSURANCE COMPANY		
ADDRESS		
CITY	STATE	ZIP
SUBSCRIBER		
BIRTHDATE		
GROUP NO.		
SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE CO.		
ADDRESS		
CITY	STATE	ZIP
SUBSCRIBER		
BIRTHDATE		
GROUP NO.		
SOCIAL SECURITY NO.		

Account Information		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
YOUR NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		
CITY	STATE	ZIP
BUSINESS TELEPHONE		EXT.
YOUR SPOUSE'S NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		
CITY	STATE	ZIP
BUSINESS TELEPHONE		EXT.

Getting to Know You		
WHOM MAY WE THANK FOR REFERRING YOU TO US?		
NAME OF OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE		
FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

FINANCIAL AGREEMENT

I agree to pay all fees and charges for treatment of the person names above. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. In the event legal action should become necessar to collect an unpaid balance due for services rendered to me or my family, I/we agree to pay collection fees, reasonable attorney's fees, filing fees, and any other such costs as the Court determines proper.

It is agreed that payment will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for collection thereof.

Signature _____ Date _____

HEALTH HISTORY

Patient Name _____

CIRCLE

YES NO 1. Are you having pain or discomfort at this time?
YES NO 2. Do you feel nervous about having dental treatment?
What can we do to make you more comfortable? Nitrous Oxide? Other?
_____
YES NO 3. Have you ever had a bad experience in the dental chair?
YES NO 4. Have you been hospitalized in the past two years?
YES NO 5. Are you in the care of a medical doctor?
Physician's Name _____
City, State _____ Phone_____
YES NO 6. Are you taking any drugs or medications?
If yes, please list the names and what it is for: _____
_____
YES NO 7. Has your physician advised premedication before dental treatment?
YES NO 8. Do you smoke or user smokeless tobacco?
9. Are you allergic or have you reacted adversely to any of the following?
YES NO Penicillin or other antibiotics.
YES NO Aspirin, codeine or other pain medications
YES NO Other medications: _____
YES NO 10. Do you have any disease, condition, or problems not listed?
If yes, please describe: _____
YES NO 11. Previous Dentist_____ City, State _____

FOR WOMEN ONLY:

YES NO 13. Are you pregnant? If yes, what is your due date? _____
YES NO 14. Are you taking birth control pills?

Have you ever had any of the following diseases or medical problems?

YES NO	Abnormal Bleeding	YES NO	Frequent Headaches	YES NO	Mitral Valve Prolapse
YES NO	Acid Reflux	YES NO	Glaucoma	YES NO	Osteoporosis
YES NO	Alcohol/Drug Abuse	YES NO	Hay Fever	YES NO	Pacemaker
YES NO	Anemia	YES NO	Heart Attack	YES NO	Psychiatric Problems
YES NO	Arthritis	YES NO	Heart Murmur	YES NO	Radiation Treatment
YES NO	Artificial Bones/Joints/Valves	YES NO	Heart Surgery	YES NO	Rheumatic/Scarlet Fever
YES NO	Blood Transfusion	YES NO	Hemophilia	YES NO	Shingles
YES NO	Cancer/Chemotherapy	YES NO	Hepatitis	YES NO	Sickle Cell Disease
YES NO	Colitis	YES NO	Herpes/Fever Blisters	YES NO	Sinus Problems
YES NO	Congenital Heart Defect	YES NO	High Blood Pressure	YES NO	Stroke
YES NO	Diabetes	YES NO	HIV+/AIDS	YES NO	Seizures
YES NO	Difficulty Breathing	YES NO	Hospitalized for Any Reason	YES NO	Thyroid Problems
YES NO	Emphysema	YES NO	Kidney Problems	YES NO	Tuberculosis (TB)
YES NO	Epilepsy	YES NO	Liver Disease	YES NO	Ulcers
YES NO	Fainting Spells	YES NO	Low Blood Pressure		

CONSENT:

The undersigned hereby authorizes the doctor or his staff to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor or his staff to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) and further authorizes and consent that the doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

Patient Signature_____ Date _____

Parent or Responsible Party _____ Relationship to Patient_____

Do not write below this line

Date Reviewed	Notes	Initials