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Spokane Valley, WA 99206

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Spokanefamilysmiles.com

Scott J. Shumway, DDS

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 ______________

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	SECONDARY DENTAL INSURANCE
Employee ______________	Employee ______________
Employer ______________	Employer ______________
Insurance Co. __________ Group# ______	Insurance Co. __________ Group# ______
Employee's S.S. No. ____ - ____ - ____	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? 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:

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

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. Shumway and his staff to use any photos taken for lecturing and continuing education purposes.

Signature ______________________________ Date ______________

Medical History Update
(For Office Use Only)

Date ________ Comments ______________________ Date ________ Comments ______________________
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