Maple Leaf Dental

7750 15th Ave NE, Suite A, Seattle, WA 98115 (206) 402-3402 office@mapleleafdental.com

Name: ______________________________ Preferred Name: __________________
(Last) (first) (middle initial)

Preferred pronoun:______________ Single: __ Married: __ Partner's Name: ______________________

Date of Birth: __________ Soc. Sec.#: ____________________ Parent : _____________________(if minor)

Address: ____________________________ City: ______________ State: _____ Zip: ________

Cell: (____) _________________ Work: (____) ____________________LandLine: (____) _______________

Email: ____ Referred by: ______________________________

Employer: ____________________________________ Occupation: ______________________________

INSURANCE INFORMATION

Primary Dental Insurance: ______________________________

Employer & Group #: ______________________________

Name of Subscriber (other than self): ______________________

DOB: ________ SS#: ______________ Ins. ID#_________________

Secondary Dental Insurance: ______________________________

Employer & Group #: ______________________________

Name of Subscriber (other than self): ______________________

DOB: ________ SS#: ______________ Ins. ID#_________________

Medical Information

Physician's Name: ______________________________

Allergies to medications? ___Yes ___No

If yes, please list: ______________________________

Other Allergies: ______________________________

Are you currently taking any medications? ___Yes ___No

List Current Medications/reason for taking: ______________________

____

____

____

Date of last physical exam? ______________________________

Other Medical Conditions: ______________________________

____

MEDICAL HISTORY

___Yes ___No Heart Disease
___Yes ___No Heart Defect
___Yes ___No Heart Murmur
___Yes ___No Heart Surgery
___Yes ___No Pacemaker
___Yes ___No Stroke
___Yes ___No High Blood Pressure
___Yes ___No Artificial Joints
___Yes ___No PreMed for Dental Care
___Yes ___No Diabetes
___Yes ___No Cancer/Tumor
___Yes ___No Radiation
___Yes ___No Chemo
___Yes ___No Epilepsy
___Yes ___No Anemia
___Yes ___No Prolonged bleeding
___Yes ___No Tuberculosis
___Yes ___No Lung Disease
___Yes ___No Asthma
___Yes ___No Inhaler use
___Yes ___No Sinus Infections
___Yes ___No Acid reflux
___Yes ___No Liver Disease
___Yes ___No Jaundice
___Yes ___No Arthritis
___Yes ___No Glaucoma
___Yes ___No Venereal Disease/STD
___Yes ___No HIV+
___Yes ___No Smoker/Vaper
___Yes ___No Marijuana use
___Yes ___No Illicit drug use
___Yes ___No Oral Contraceptives
___Yes ___No Pregnant--DueDate:______
___Yes ___No Surgery:

I am financially responsible for my own account. I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. If insurance coverage exists, I authorize payment to go directly to my dentist.

______________________________________ ______________________
Signature Date