

**BARKLEY BOULEVARD DENTAL CARE  
LES SEELYE, DDS**

We are pleased you have selected us to provide dental care for you and your family.  
How did you hear about our office? Friend/Family\_\_\_ Website\_\_\_ Insurance\_\_\_ Mailer\_\_\_ Other\_\_\_  
Name of family or friend who referred you\_\_\_\_\_

**PATIENT INFORMATION**

Last Name\_\_\_\_\_ First Name\_\_\_\_\_ Middle initial\_\_\_\_\_  
Preferred Name\_\_\_\_\_ Birthdate\_\_\_\_\_  
Address\_\_\_\_\_ City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_  
Mailing address \_\_\_\_\_  
Primary Contact Phone ( ) \_\_\_\_\_ Home / Cell / Work (please circle one)  
Secondary Contact Phone ( ) \_\_\_\_\_ Home / Cell / Work (please circle one)  
May we leave a message at home or on voicemail? YES/NO  
Email address \_\_\_\_\_  
Social Sec.# \_\_\_\_\_ Sex M F Mar.Status\_\_\_\_\_  
Employer \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Phone # ( ) \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone # ( ) \_\_\_\_\_  
Nearest relative not living with you \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

**RESPONSIBLE PARTY** (If under 18 years of age)

Name of Person Responsible for Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone# ( ) \_\_\_\_\_ Social Sec.# \_\_\_\_\_ Birthdate \_\_\_\_\_

**INSURANCE INFORMATION**

Subscriber/Insured's Name \_\_\_\_\_ Social Sec.# \_\_\_\_\_  
Subscriber/Insured's Employer \_\_\_\_\_ Birthdate \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Subsc.ID# \_\_\_\_\_

Do you have secondary insurance? Yes / No

(more on other side)

**MEDICAL INFORMATION**

Have you been hospitalized or under the care of a medical doctor in the last 2 years  
Other than routine visits. ....Yes No  
Please list any medications you are currently taking \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever taken bisphosphonates or other meds for Osteoporosis? \_\_\_\_\_

Are you sensitive or allergic to any medications.....Yes No

Have you used or do you currently use tobacco products? If yes, which one: \_\_\_\_\_

**Please circle to indicate which of the following you have had or have at the present.**

- |                        |                           |                       |
|------------------------|---------------------------|-----------------------|
| Allergy to Latex       | Cold Sores/Fever Blisters | HIV positive/AIDS     |
| Allergy to Metal       | Diabetes                  | Kidney Trouble        |
| Allergies or Hives     | Substance Abuse           | Liver Disease         |
| Anemia                 | Epilepsy/Seizures         | Mitral Valve Prolapse |
| Angina Pectoris        | Fainting/Dizziness        | Osteoporosis          |
| Arthritis              | Heart Attack              | Pacemaker             |
| Artificial Heart Valve | Heart Disease             | Radiation Therapy     |
| Artificial Joints      | Heart Murmur              | Rheumatic Fever       |
| Asthma                 | Heart Surgery             | Stroke                |
| Cancer                 | Hepatitis A B C           | Thyroid Problems      |
| Chemotherapy           | High Blood Pressure       | Tuberculosis          |

Do you have or have you had any disease, condition or problem not listed?.....Yes No  
If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

**For Women:** Are you pregnant? Yes No Are you nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and best to my knowledge.

**CONSENT:**

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with the patient. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor may choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a finance charge may be added to my account and my account may be sent to a Collection Agency.
4. I understand that it is my responsibility to advise your office of any changes in the information on this form and the use of my social security number to file my claim.

**Patient or Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Office use only: \_\_\_\_\_

## Welcome to Barkley Boulevard Dental Care

We look forward to providing you the highest quality and most comfortable care possible.  
To accomplish this we would like to get some additional information.

What is your primary reason for being here today?

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Are you in any dental discomfort or pain? YES\_\_\_ NO\_\_\_

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Previous dentist and last visit date? \_\_\_\_\_

Have you ever been told to PREMED (take an antibiotic *before* dental treatment) ?

Yes\_\_\_ NO\_\_\_

Do your gums bleed when brushing or flossing? YES\_\_\_ NO\_\_\_

Have you ever been told you have periodontal disease or gum problems? YES\_\_\_ NO\_\_\_

Have you ever had discomfort during your cleaning or periodontal therapy? YES\_\_\_ NO\_\_\_

Do you have any questions on how to improve your dental home care? YES\_\_\_ NO\_\_\_

With few exceptions, Whatcom County does not have fluoridated water. Would you like Fluoride treatment to reduce your risk of cavities? YES\_\_\_ NO\_\_\_

(There is a fee of \$15 if not covered by insurance)

If you have problems lying back comfortably, would a pillow be useful for your knees, back or neck?

YES\_\_\_ NO\_\_\_

What can we do to give you the best dental experience?

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(More on other side)

Are your teeth sensitive to temperatures, biting or sweets? YES\_\_\_\_ NO\_\_\_\_

Do you have any jaw pain, popping or clicking? YES\_\_\_\_ NO\_\_\_\_

Do you clench or grind your teeth? YES\_\_\_\_ NO\_\_\_\_

Do you have headaches? YES\_\_\_\_ No\_\_\_\_

Are you aware of any excessive wear on your teeth? YES\_\_\_\_ NO\_\_\_\_

Do you currently have any oral appliances? YES\_\_\_\_ NO\_\_\_\_ Ortho retainers – nightguards-

Do you snore? YES\_\_\_\_ NO\_\_\_\_

If you could change anything about your teeth or smile it would be?

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Thank you and welcome to our office.

Office use only: \_\_\_\_\_