BARKLEY BOULEVARD DENTAL CARE

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 ☐ Google ☐ Other

Name of family or friend who referred you: _____

PATIENT INFORMATION

Last Name_____ First Name_____ Middle Initial_____

Preferred Name _____ Preferred Pronoun_____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_____ SSN _____

Employer _____

Spouse/Partner 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_____

Address _____City/State _____Zip _____

Phone# _____ SSN _____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)	YES / NO
Are you currently taking any medications? If so please list: _____ _____	YES / NO
Have you ever taken bisphosphonates or other meds for Osteoporosis?	YES/ NO
Are you sensitive or allergic to any medications? If so, please list: _____	YES / NO
Have you used or do you currently use (please circle) tobacco, vape, marijuana or nicotine pouches? How Often? _____	YES / NO
Have you had a recent joint replacement or heart valve replacement?	YES / NO

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

Allergies or Hives	Allergy to Latex/ Metals	Anemia	Angina Pectoris
Anxiety / Depression	Arthritis	Artificial Heart Valve	Artificial Joints
Asthma	Auto Immune Disorder	Cancer	Chemotherapy
COVID 19	Crohn's	Cold Sores	Diabetes I / II
Epilepsy / Seizures	Fainting / Dizziness	Heart Failure (CHF)	Heart Surgery
Heart Attack	Heart Disease	Heart Murmur	Hepatitis A B C
High Blood Pressure	High Cholesterol	HIV positive / AIDS	Kidney / Liver Problems
Liver Disease	Mitral Valve Prolapse	Memory Loss / Dementia	Osteoporosis
Pacemaker	Rheumatic Fever	Radiation Therapy	Substance Abuse
Stroke	Thyroid problems		

Do you have or have you had any disease, condition or problem not listed? If so, please list: _____ _____	YES / NO

For Women only:

Are you pregnant? YES / NO	Are you nursing? YES / NO	Taking birth control pills? YES / NO	Perimenopause/ menopause? 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 to the best of my knowledge.

CONSENT:

You and/or your assignees are hereby authorized to contact me at any telephone number, including cell numbers and email address provided by me or otherwise obtained by you, using text, email and to leave messages on such devices.

I authorize treatment of the person named above and agree to accept full responsibility for payment regardless of any third party responsibility. I hereby authorize my Provider's office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper medical care. I authorize the release of any medical information requested by my insurance company. I authorize payment of benefits directly to my Provider's office. Finance charges maybe charged to balances over 60 days at the rate of 9% per annum. If my account becomes past due, I/we agree to pay all attorney fees, court costs, filing fees and process service fees which may be assesses by any collection agency or law firm retained to pursue the matter and for the venue and jurisdiction to be in Whatcom County.

I certify that all the above information is correct and I have read, understand and agree to the above statements.

Patient or Responsible Party Signature:

_____Date:_____

Office use only: _____ B/P _____

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DENTAL HISTORY

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? _____

Previous dentist and last visit date? _____

Are you in any dental discomfort or pain? If yes, please describe. _____	YES / NO
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? (Fee of $20 if not covered by insurance)	YES / NO
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? (Ortho retainers, nightguards)	YES / NO
Do you snore?	YES / NO
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? _____

_____

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

_____

Thank you and welcome to our office.