BOHM DENTAL
CARRIE L. BOHM, DDS
8105 166th Ave NE #201, Redmond, WA 98052
425-885-5119 | info@bohmdental.com

Patient Name: _____
Date: _____

Patient Registration Form

Welcome to Bohm Dental! Thank you for choosing our dental office to provide you with dental care. To get started, please complete the form below in its entirety. Our staff front office staff is happy to assist you if you have any questions. Some fields may be left blank if they do not apply to you.

Patient Information

Today's Date (MM/DD/YYYY):___/___/___ File #:_____

Patient Name: _____
Last First M

Nickname: _____ ☐ Male ☐ Female

Birthdate (MM/DD/YYYY):___/___/___ Age #:_____

Address:_____

_____
City State Zip

Phone # (Home): (_____) _____

Phone # (Work): (_____) _____ ext:_____

Phone # (Cell): (_____) _____

Email: _____

Referred by: _____

Employer: _____ How long: _____

Employer Address:_____

_____
City State Zip

Occupation: _____

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced

Spouse Name: _____

How many children do you have: _____

Insurance Information

Primary Dental Insurance

Co. Name: _____

Address:_____

_____
City State Zip

Phone #: (_____) _____

Insured's Name:_____

Relation to Patient: _____ Birthdate:___/___/___

Insured's ID :_____

Group # (plan, local or policy #): _____

Insured's Employer :_____

Secondary Dental Insurance

Co. Name: _____

Address:_____

_____
City State Zip

Phone #: (_____) _____

Insured's Name:_____

Relation to Patient: _____ Birthdate:___/___/___

Insured's ID :_____

Group # (plan, local or policy #): _____

Insured's Employer :_____

Account Information

Person ultimately responsible for this account

Name: _____

Relation: _____

Social Security Number: _____

Driver's License #: _____

Address:_____

_____
City State Zip

Phone # (Home): (_____) _____

Phone # (Work): (_____) _____ ext:_____

Emergency Contact

Emergency Contact Name: _____

Phone # (Home): (_____) _____

Phone # (Work): (_____) _____ ext:_____

Phone # (Cell): (_____) _____

Your Medical Doctor's Name: _____

Your Medical Doctor's Phone #: (_____) _____

Your Medical Doctor's Phone #: (_____) _____

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Patient Name: _____
Date: _____

Dental Information and History

Reason for Today's Visit? ☐ Exam ☐ Emergency ☐ Consultation **Are you in Pain:** ☐ Yes ☐ No **For how long**:_____

Please indicate any of the following conditions you are currently or have recently experienced:

- ☐ Discomfort, clicking, or popping in jaw
- ☐ Red, swollen, or bleeding gums
- ☐ Sensitive tooth, teeth, or gums
- ☐ Blisters or sores in or around the mouth
- ☐ Lost or broken filling(s)
- ☐ Teeth grinding
- ☐ Ringing in ears
- ☐ Broken or chipped tooth
- ☐ Stained teeth
- ☐ Locking jaw
- ☐ Bad breath

Other conditions:_____

Do you require pre-medication? ☐ Yes ☐ No ☐ I don't know

Previous dentist (name):_____ Phone #: (____) _____

Last Dental Exam (MM/DD/YYYY):____ /_____ /_____ Last Dental X-rays (MM/DD/YYYY): _____ /_____ /_____

Brushing frequency: ☐ > 3 per day ☐ 3x per day ☐ 2x per day ☐ 1+ per day ☐ 3 - 6 times per week ☐ <3 times per week

Flossing frequency: ☐ > 2 per day ☐ 2x per day ☐ 1x per day ☐ 2 - 6 times per week ☐ once per week ☐ <1 a week

Preferred toothbrush ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile: (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Medical Information and History

What medications are you taking? ☐ Nerve pills ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Osteoporosis Medication

Other medication(s):_____

Have you ever taken: ☐ Biophosphates (ex. Aredia, Fosamax) ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Osteoporosis medication

Do you have or have you had any of the following diseases, medical conditions, or procedures?

- ☐ Heart Attack/Stroke
- ☐ Heart Surgery/Pacemaker
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Artificial Valves
- ☐ Heart Disease
- ☐ Congenital heart Defect
- ☐ Chest Pains
- ☐ Scarlet Fever
- ☐ Nervousness
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Liver problems
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Stomach Problems/Ulcers
- ☐ Psychiatric Problems
- ☐ Venereal Disease
- ☐ Alcohol/Drug Abuse
- ☐ Tuberculosis TB
- ☐ Jaw Problems TMJ/TMD
- ☐ Cancer/Tumors
- ☐ Shingles
- ☐ Hepatitis
- ☐ HIV+/AIDS/ARC
- ☐ Arthritis/Rheumatism
- ☐ Artificial Bones, Joints
- ☐ Emphysema
- ☐ Fainting/Seizures, Epilepsy
- ☐ Severe, Frequent Headaches
- ☐ FrequenT Neck Pain
- ☐ Back Problems
- ☐ Cosmetic Surgery
- ☐ Xray or Cobalt Treat
- ☐ Chemotherapy
- ☐ Asthma
- ☐ Difficulty Breathing
- ☐ Diabetes/Hypoglycemia
- ☐ Leukemia
- ☐ Anemia
- ☐ High, Low Blood Pressure
- ☐ Bleeding Problems
- ☐ Glaucoma

Please list any other surgeries or medical condition you have or have ever had:_____

_____

Are you allergic to: ☐ Latex ☐ Penicilin/Amoxicilin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics

Foods:_____ Others: _____

Do you use tobacco? ☐ No ☐ Yes / How used: _____ How Much: _____ How Long: _____

Rate your general health (from 1 to 10):____ Do you wear contact lenses? ☐ Yes ☐ No

FOR WOMEN. Taking Birth Control Pills: ☐ Yes ☐ No How many children have you had: _____

Are you pregnant? ☐ No ☐ Yes / How long: _____ Are you nursing? ☐ No ☐ Yes

- We invite you to ask any questions regarding our services. The best dental health services are based on friendly, honest mutual understanding.
- Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with our office manager. If your account is not paid within 90 days after the day of service and no financial arrangements have been made, you will be responsible for legal fees collection agency fees, interest charges and any other expenses incurred in collecting your account.
- We value your time and ask that you value ours. Appointment cancellations with less than 24 hours notice of the appointment time or missed appointments will result in a $25.00 charge per hour of the originally scheduled appointment.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Name: _____ **Date** (mm/dd/yyyy): _____ /_____ /_____

☐ Adult Patient ☐ Patient or Guardian ☐ Spouse