

# WELCOME!

Welcome to our private care dental office. My Team and I consider ourselves a group of health care professionals whose primary concerns are the prevention and treatment of dental disease and the creation of pleasing aesthetics in those guests who choose to place themselves in our care.

We believe in providing Excellence. Each of us maintains a continuing commitment to progress, innovation and education, with the goal of developing the best dental care possible.

We establish our treatment based on the principle of choice. We respect your right to choose what you think is best for your future health, based on the most current and complete information we can provide. It is our sincere hope that you will strive for the highest level of quality care.

A result of this philosophy is our stellar reputation, and our passion for excellence and innovation in dentistry. Our guests have come to know what they can expect of us: only the very best.

Dr. Kari Chellis, RDH, DDS

# *Smile Secrets*

*Cosmetic, Preventative & Restorative Dentistry*

**Jefferson Square Professional Building, 4700 42<sup>nd</sup> Ave SW, Suite 555, West Seattle, WA 98116**



**206.935.5522 p, 206.932.4577 f**

## VISION

We want to help our guests have a better life. We believe we can improve the quality of their lives by helping them achieve ideal dental health and their dental dreams. We believe that people who have optimal dental health will be happier, healthier and live longer. Great looking smiles help people feel more confident. They will smile more and be happier!

We are in the business of improving self-esteem and providing peace of mind for those guests seeking the best! Guests who appreciate us and our philosophies of preventing and healing disease, and who are willing to pay for our exceptionally high level of quality and service. We will provide the highest level of care at the highest level of profitability, acknowledging that without profit, there is no purpose.

We will help our guests look and feel better. We will do this based on the desires of our guests by asking questions and listening intently. We want our service to be gentle and supportive as well as technically advanced. Our guest's priorities, values and expectations will guide us in designing their dream smile. We believe that an informed, involved and satisfied guest is most likely to achieve the highest level of health.

We will strive to schedule our care in a manner that creates a comforting and relaxing environment for our guests as well as for our Team, and in a manner that allows us to start and stop on time. We will not cut corners. We want to have fun! We will ask satisfied guests we enjoy to refer their friends and family members. We will provide dentistry that will withstand the test of time, so that we may be proud of our work, our fees, our image and of our reputation!

## Patient Information

Date:		Preferred Name:			
Patient Name:	Last	First		MI	
Title: <input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Mrs <input type="checkbox"/> Dr		SS #: /      /		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:					
Street		City		State	Zip
Email Address				Birth date:	
Family Status:	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

Home Phone:	Cell Phone:	Work Phone:
Best time and number to call:		
We confirm all appointments via e-mail or text message or both. What is your preferred method of correspondence?		
<input type="checkbox"/> Email <input type="checkbox"/> Text Message <input type="checkbox"/> Both		

Whom may we thank for referring you to our office?		
Name or Source (website, Citysearch, Reviews, etc.):		
If patient is under the age of 18, parent or guardian's signature:		
In case of emergency, please notify:	Name:	Phone:                      Relationship:


  
*Cosmetic, Preventative & Restorative Dentistry*

## Primary Insurance Information

Name of Insured:	Last	First	Middle
Insured's Birth Date:	ID #:	Group #	
Insured's Address:			
Street	City	State	Zip
Insured's Employer Name:			
Patient's Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Insurance Plan Name:		Primary Dental Insurance Phone Number:	
Insurance Address:			
Street	City	State	Zip

## Additional Insurance Coverage

Name of Insured:	Last	First	Middle
Insured's Birth Date:	ID #:	Group #	
Insured's Address:			
Street	City	State	Zip
Insured's Employer Name:			
Patient's Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Insurance Plan Name:		Secondary Dental Insurance Phone Number:	
Insurance Address:			
Street	City	State	Zip

I authorize my insurance company to pay all benefits for services rendered. I understand my insurance policy is a contract between my employer and the insurance company. If for any reason the estimated amount is not paid by my insurance, it will become my responsibility. For insurance benefits and guidelines, please contact your insurance company or refer to your benefits manual.

We consider all appointments confirmed at the time they are scheduled. We request a courtesy of a 3-business-day notice for any appointment changes. We reserve the right to charge a 12% Finance Charge on Account Balances over 60 days old.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Getting to Know You

What attracted you to our office?

What are your main concerns?

- Comfort       Health       Endurance       Appearance

How might these concerns change in the future?

What would you like to have happen today?

What would you like us to know about you and your past dental experiences?

- It has been good       I need help getting on track  
 I've had bad experiences       I've had an accident that affected my teeth  
 I've had braces       I've had TMJ pain  
 Other. Please describe:

Please tell us a little about yourself. For example, family, pets, hobbies, interests, etc.

How is your overall physical (non-dental) health?

- Great!       Good       Fair       Poor       Frail

What are your expectations for a successful result?

- Relief from pain       Whiter Teeth  
 Dental Health       Straighter Teeth  
 Chew better       A Smile Makeover  
 Eliminate headaches       I'm not sure yet, but tell me about my options  
 Help me save my teeth!  
 Other. Please describe:

What would you like to know about us?

- |   |  |
|---|--|
| <input type="checkbox"/> Will I feel any pain?                                    | <input type="checkbox"/> Can you make the numbness go away faster?   |
| <input type="checkbox"/> Do you have "Laughing Gas"?                              | <input type="checkbox"/> What are your Infection Control Procedures? |
| <input type="checkbox"/> Can I sleep through my appointments?                     | <input type="checkbox"/> How much time will this take?               |
| <input type="checkbox"/> Can you minimize the number of visits?                   | <input type="checkbox"/> Do you have payment plans?                  |
| <input type="checkbox"/> Can you minimize the number of times I have to get numb? | <input type="checkbox"/> Do you have room for my family and friends? |
| <input type="checkbox"/> Other. Please describe:                                  |  |

## Health History

Date of last medical exam?	Date of last dental exam?
Have you been hospitalized in the last 5 years? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, what for?
Are you currently receiving care? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, what is the nature of your care?
Are you required to Pre-Medicate? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, for what reason?
Please list the names and phone numbers of all physicians who are currently providing you care:	
Please list all prescription medications you are currently taking:	
Please list any OTC medicines you are currently taking:	
Please list any herbal supplements you are currently taking:	
Do you have abnormal Blood Pressure? <input type="checkbox"/> Low <input type="checkbox"/> High	Do you take any medications for Blood Pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you allergic to: <input type="checkbox"/> Sulfa <input type="checkbox"/> Local Anesthetics <input type="checkbox"/> Valium	<input type="checkbox"/> Penicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Codeine

Are you allergic to:

- Other antibiotics
- Other sedatives
- Other allergies

Please list:

Please list:

Please describe:

Have you ever had or do you have any of the following conditions?

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Attack within the last 6 months   | <input type="checkbox"/> Joint Replacement                   |
| <input type="checkbox"/> Heart (Surgery, Disease, Attack)        | <input type="checkbox"/> Hepatitis, Any Form                 |
| <input type="checkbox"/> Abnormal Heart Condition                | <input type="checkbox"/> Drug/Alcohol Addiction              |
| <input type="checkbox"/> Bacterial Endocarditis                  | <input type="checkbox"/> Previous Biopsies                   |
| <input type="checkbox"/> Prosthetic Heart Valve                  | <input type="checkbox"/> Radiation Therapy                   |
| <input type="checkbox"/> Congestive Heart Disease, excluding MVP | <input type="checkbox"/> Unintentional Weight Loss/Gain      |
| <input type="checkbox"/> Heart Transplant                        | <input type="checkbox"/> Mental Disorder                     |
| <input type="checkbox"/> Rheumatic Fever                         | <input type="checkbox"/> Nervous Condition or Depression     |
| <input type="checkbox"/> Abnormal Bleeding from a cut            | <input type="checkbox"/> Herpes/Cold Sores                   |
| <input type="checkbox"/> Asthma                                  | <input type="checkbox"/> Sore/Enlarged Lymph Nodes           |
| <input type="checkbox"/> Emphysema or other Respiratory Illness  | <input type="checkbox"/> Slow-Healing Mouth Sores            |
| <input type="checkbox"/> Anemia                                  | <input type="checkbox"/> Recurrent Illnesses                 |
| <input type="checkbox"/> Epilepsy                                | <input type="checkbox"/> Glaucoma                            |
| <input type="checkbox"/> Thyroid Condition                       | <input type="checkbox"/> Eating Disorder                     |
| <input type="checkbox"/> Liver Disease (including Jaundice)      | <input type="checkbox"/> Latex Sensitivity                   |
| <input type="checkbox"/> Kidney Disease                          |  |
| <input type="checkbox"/> Cancer                                  | What type? _____   |
| <input type="checkbox"/> HIV+ or AIDS related Complex            | What was your last CD4 Count? _____                          |
| <input type="checkbox"/> Diabetes                                | What was your last HbA1c?                                    |
|  | <input type="checkbox"/> < 6.5%                              |
|  | <input type="checkbox"/> 6.5 –8.5%                           |
|  | <input type="checkbox"/> > 8.5%                              |
| <input type="checkbox"/> Osteoporosis                            | Have you ever taken bisphosphonates (Fosamax, Actonel, etc)? |
|  | <input type="checkbox"/> Yes                                 |
|  | <input type="checkbox"/> No                                  |

Do you use tobacco products of any kind?

- |                                |  |                                       |                              |
|--------------------------------|--|---------------------------------------|------------------------------|
| <input type="checkbox"/> Never | <input type="checkbox"/> I used to, but I quit | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Yes |
|                                | When?  |                                       | How much /day?               |

**For Women:**

Are you Pregnant?

- Yes
- No

Are you a Nursing Mother?

- Yes
- No

Are you planning a pregnancy in the near future?

- Yes
- No

Are you taking Birth Control Pills?

- Yes
- No

Have you ever had or are you having TMJ/jaw discomfort/headaches?	
<input type="checkbox"/> Yes	If yes, how often?
<input type="checkbox"/> No	
Are you aware of clenching or grinding?	Do you wear a Night Guard?
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No
Are you aware of any sleeping disorder (apnea, etc)?	
<input type="checkbox"/> Yes	
<input type="checkbox"/> No	
<b>For Patients interested in Sedation Dentistry:</b>	
Do you take Antacids (Tums, Cimetidine/Tagamet, Prilosec, Nexium)?	
<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
<input type="checkbox"/> Yes, regularly	<input type="checkbox"/> Every meal
Do you take St John's Wort?	
<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
<input type="checkbox"/> Regularly	<input type="checkbox"/> Daily
Do you drink grapefruit juice?	
<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
<input type="checkbox"/> Yes, regularly	<input type="checkbox"/> Every meal
Do you take Protease Inhibitors (Nefazadone/ Serzone, etc)?	
<input type="checkbox"/> Yes	
<input type="checkbox"/> No	
Do you take FLUoxetine/Prozac?	
<input type="checkbox"/> Yes	
<input type="checkbox"/> No	
What is your approximate Blood Pressure?	
What is your approximate Weight?	
How much sugar is there in your diet?	
<input type="checkbox"/> Slight	<input type="checkbox"/> Moderate
<input type="checkbox"/> High	
Do you smoke?	
<input type="checkbox"/> Yes	
<input type="checkbox"/> No	

I understand the above information is necessary to provide me with optimal dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify you, Dr Chellis, of changes in my health and/or medications.

Dr Chellis guarantees the materials she uses and the workmanship of her restorative care for a period of 5 years, as long as you remain an active patient, come in for your 6 month recare visits and are following her recommendations.

Initials: \_\_\_\_\_

*Smile Secrets*

*...for dentistry that withstands the test of time...  
guaranteed!*