Jae Seon Kim DDS,MSD,FACP
2046 Westlake Ave N, Suite 204, Seattle, WA, 98109
206.284.4505
info@pacificmoderndentistry.com
www.pacificmoderndentistry.com

Medical and Dental History

Patient Name: ____Birthdate: ___________________________________

Physician Name: ____Phone Number: _____________________________

Previous Dentist Name: ____________________________________Phone Number________________________________

Do you have or have you ever had:

Alcohol/Drug Depend
Allergy To:
____
____
Anemia/Blood Disorder
Art. Valve/Repair
Arthritis
Artificial Prosthesis
Asthma
Blood Disease
Cancer Type:
____
Chemotherapy
Depression
Diabetes
Digestive Disorder:
____
Dizziness
Emotional Problem
Emphysema/Sarcoidosis
Endocarditis
Epilepsy, Seizures
Excessive Bleeding
Fainting
General Health
Glasses/Contact Lens

Glaucoma
Hay Fever
Head, Neck Injury:
____
Heart Conditions:
____
____
Hepatitis Type:
High/Low Blood Pressure
High/Low Cholesterol
HIV/Aids
Hormone Deficiency
Jaundice
Kidney Disease
Liver Disease
Lumps/Swelling Mouth
Neurologic Condition
____
Nitrous Oxide
Osteoporosis
Other:
____
____
Pacemaker/Defibrillator
Pregnancy

Premedication Required:
____
Prostate Disorder
Psychiatric Treatment
Radiation Treatment
Respiratory Condition
____
Rheum/Scarlet Fever
Smoker
Stomach/ Ulcer
Stroke/TIA
Medication, Vitamin, Supplement:
____
____
____
____
Thyroid/ Parathyroid
Tuberculosis
Tumor, Growth
Undergoing Treatment
____
____
____
Venereal Disease
Viral Infection
Weight Management

Any other medical or dental history information you would like us to know that would aid us in treatment of your care?

____

____

What is your immediate Concern:

____

____

Have you had an unfavorable dental experience? YES NO
Have you had complications from past dental treatment? YES NO
Did you ever have orthodontic treatment? YES, if so when____________ NO
Is there anything about the appearance of your teeth that you would like to change?

____

Have you ever whitened your teeth? YES NO
Have you been disappointed with the appearance of previous dental work? YES NO
Do you have problems with your jaw? YES NO
Do you have problems chewing gum, bagel, and hard foods? YES NO
Have your teeth changed in the last 5 years? YES NO
Are your teeth crowding or developing spaces? YES NO
Do you have more than one bite and squeeze to make your tooth fit together? YES NO
Do you chew ice, bite your nails, and use your teeth to hold objects? YES NO
Do you clench your teeth in the day or night time? YES NO
Do you have any problems with sleep or wake up due to your teeth? YES NO
Do you wear or have you worn a mouth appliance? YES NO
Have you had any cavities with in the past 3 years? YES, if so where___________________ NO
Do you feel your mouth is dry? YES NO
Do you feel or notice any holes on any surface of your teeth? YES, if so where___________________ NO
Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing? YES, if so where________________ NO
Do you have grooves or notches on your teeth by the gum? YES NO
Do you get food caught in your teeth? YES, if so where________________ NO
Do your gums bleed when brushing or flossing? YES NO
Have you ever been treated for gum disease? YES, if so when________________ NO
Have you ever noticed an unpleasant taste or odor in your mouth? YES NO

Any other medical or dental information you would like us to know that would aid us in treatment of your care?

____

____

Signature: ____ Date: ______________________