GERALD L BECKER, DDS

715 N 182nd St # 401 Shoreline, WA 98133 206.542.4848

Patient Information

Date:_____

Patients Name: (Last)_____(First)_____(Middle Int)_____

Address:_____(City)_____(State)_____(Zip)_____

How long at this address?_____ Hm Phone#_____ Wk Phone#_____

Email_____ Cell Phone#_____

May we contact you with current topics of interest from Dr. Becker? Yes ○ No ○

Birthdate_____ Social Security #_____

Employer:_____ Occupation:_____ No. Years:_____

Whom may we thank for referring you to our office? _____

Marital Status:_____ Spouse's Name:_____ Spouse's Date of Birth_____

Spouse's Employer:_____ Occupation:_____ No. Years:_____

Dental Insurance Information

Primary

Subscriber's Name_____ Subscriber's SS/ID#_____

Dental Insurance Co._____ Group #_____

Insurance Address:_____ Phone #_____

Secondary

Subscriber's Name_____ Subscriber's SS/ID#_____

Dental Insurance Co._____ Group #_____

Insurance Address:_____ Phone #_____

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Emergency Information

Name of nearest relative not living with you:_____

Address:_____ Phone #_____

What are your dental expectations and how can we fulfill them?

(Please check the appropriate boxes)

- ☐ Relieve current pain and discomfort. Location of discomfort in mouth?_____
- ☐ Maintain existing oral health, replace fillings only as necessary.
- ☐ Interested in learning more about materials other than silver-mercury amalgam.
- ☐ Interested in being a part of the decision process.
- ☐ Interested in replacing existing fillings with more inert materials.
- ☐ Interested in removing all metal and replacing with non-metallic dentistry.
- ☐ Here to learn more about alternative dentistry.
- ☐ Interested in learning more about root canals and alternative choices.
- ☐ Looking for a new dentist for myself and family.
- ☐ Interested in Materials Testing before any new fillings are placed.
- ☐ Do not visit a dentist regularly, reason: Time constraints ☐ Ill health ☐ Transportation ☐ No Insurance ☐ Fearful ☐ Previous dental frustrations ☐ Finances ☐ Other_____

Have you experienced any of the following? Gum Recession ☐ Sensitive Roots ☐ Bleeding Gums ☐

Notching of the enamel at gumline ☐ Loss of teeth ☐ Bone loss ☐ Jaw or Joint Pain ☐ Nightguard ☐

Clicking or Popping of the jaw joint ☐ Root Canals ☐ Periodontal Surgery ☐ Overall Healthy Teeth ☐

Orthodontics (braces) If so, how long?_____ What age?_____

What factors determine your choices about dentistry? Durability ☐ Esthetic ☐ Comfort ☐

Non-Toxic materials ☐ Ins Benefits ☐ Doctor who listens ☐ Bite Specialist ☐ Holistic Approach ☐

Cost ☐ Office Location ☐ Office Staff ☐ Office Hours ☐ Technical Excellence ☐

Respect for the individual ☐ Integration with Medical Practitioner ☐

Dental Apprehension Level: Low ○ Moderate ○ High ○

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Medical Information

Is your health compromised? If so, when did it begin?_____ What do you believe was the cause of your illness?_____

Name of primary care physician:_____ Phone:_____

Names of other healthcare providers:_____

Date of last complete physical:_____

Are you currently seeing someone for overall health management:_____ Is this person familiar with a heavy-metal detox protocol?_____

Please check where appropriate:

- ☐ Medically directed to remove your mercury-silver fillings
- ☐ Personally concerned about mercury-silver fillings/toxicity
- ☐ Medical or person concern about biocompatibility of dental materials

Are you allergic or have you reacted adversely to the following medications:

Aspiri ☐ Nitrous Oxide ☐ Valium ☐ Local Anesthetic ☐ Darvon ☐ Codeine ☐

Antibiotics ☐ Demerol ☐ Erythromycin ☐ Tetracycline ☐ Penicillin ☐ Percodan ☐

Sleeping pills ☐ Other:_____

What medications/herbs have you taken over the past two years?_____

_____

Check any of the following which you have had or have at the present:

NOTES:

☐	Heart Failure	☐	Hay Fever	☐	A.I.D.S.		
☐	Heart Disease or Attack	☐	Long-term cough	☐	HIV Positive		
☐	Heart Pacemaker	☐	Tuberculosis	☐	Hepatitis A		
☐	Heart Surgery	☐	Bruise Easily	☐	Hepatitis B		
☐	Cosmetic Surgery	☐	Asthma	☐	Hepatitis C		
☐	Stroke	☐	Smoke now/past	☐	Yellow Jaundice		
☐	Rheumatic Fever	☐	Sinus Trouble	☐	Liver Disease		

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☐ Heart Failure	☐ Hay Fever	☐ A.I.D.S.	
☐ Congenital Heart Lesions	☐ Allergies or Hives	☐ Drug Addiction	
☐ Scarlet Fever	☐ Diabetes	☐ Hemophilia	
☐ Artificial Heart Valve	☐ Thyroid Disease	☐ Venereal Disease	
☐ Artificial Joints (Hip, Knee)	☐ X-Ray or Cobalt Treatment	☐ Epilepsy or Seizures	
☐ Anemia	☐ Chemotherapy	☐ Fainting or Dizzy Spells	
☐ Kidney Trouble	☐ Arthritis	☐ Anxiety	
☐ Ulcers	☐ Rheumatism	☐ Long term Depression	
☐ Cortisone Medicine	☐ Psychiatric Treatment	☐ Blood Transfusion	

Do you have any disease, condition or problem listed:_____

Additional Comments:_____

_____

_____

How can we best communicate with you? Visual Aids ☐ Verbal Explanation ☐ Want detail ☐ Limit Details ☐

Last visit to the dentist:_____ Reason for visit:_____

Name of Previous Dentist:_____

Date of last cleaning:_____Date of last X-rays:_____

Stress level over the past year: Minimal ○ Moderate ○ Significant ○

What do you do for stress reduction? Exercise ☐ Meditate ☐ Read ☐ Yoga ☐

Other_____

What in life gives you enjoyment? Music ☐ Reading ☐ Animals ☐ Children ☐ Working ☐

Other:_____

Certificate of Information and Consent for Care:

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all questions truthfully and to the best of my knowledge. I hereby grant permission to the doctor to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental care. I understand any photographs may be used for documentation and for educational purposes. I also understand where appropriate, credit reports may be obtained.

Signature:_____ **Date:**_____

(Signature of parent/guardian if patient is under 18 years or a student) (Relationship to patient):_____