



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

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:

Aspirin 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): _____