



425.558.1515 | info@shawnkellerdds.com | 7530 164th Ave NE, Suite A-230, Redmond, WA 98052

PLEASE HELP US UNDERSTAND YOU!

Patient Name: _____

Date: _____

Our office is different in that we give our patients our full attention.

We schedule one patient at a time, find out what is important to you and deliver what we promise.

Please answer the following questions so we can better understand your needs.

How can we help you?

Are you looking for a new dental home? yes no

Do you plan on returning to your old dentist after your treatment is complete? yes no

I am interested in:

- | | | |
|--|--|--|
| <input type="checkbox"/> Same Day New Smile™ (All-on-four) | <input type="checkbox"/> Smile Makeover | <input type="checkbox"/> Metal-free Implants |
| <input type="checkbox"/> Stem Cell Therapy | <input type="checkbox"/> TMJD Treatment | <input type="checkbox"/> Sedation Dentistry |
| <input type="checkbox"/> Golden Ratio Rejuvenation™
(Non-surgical Facelift) | <input type="checkbox"/> Filling upgrade | |

What is your time frame for the above? _____

Your first visit is designed to answer your questions and allow us to see if we are the right dentist for you.

If you feel we are not the best fit, we will be happy to refer you to someone we know is a better match. If you feel we can help you, we will take records, do a thorough examination and give you specific options for your dental treatment.

Please begin thinking about the following: How important are the following concepts?

DENTAL HEALTH, PREVENTION, DENTAL COSMETICS, and FACIAL COSMETICS?

We will be discussing this with you shortly. Thank you!

*Shawn Keller, DDS,
and the Team at Smiles by Design*



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YOUR HEALTH HISTORY

Patient Name _____ Date Of Birth _____

Address w/Zip _____

Home Phone # _____ Cell Phone # _____

Email _____ Who May We Thank For Referring You To Us _____

Employer _____ Work Phone _____

Primary Physician's Name _____ Physician Phone # _____

Date of Last Physical _____ Emergency Contact _____

Relationship to Emergency Contact _____ Contact Phone # _____

Please answer Yes or No to the following:

- | | | | | | |
|---|--|------------------------|--|--------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ANEMIA | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on | |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Head/Neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleep Apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally,
with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Popping | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Limited Opening | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | Congested Ears | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ringling Ears | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Posture Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Clenching | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Grinding | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Facial Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck Ache | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bell's palsy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

List any medications you are currently taking: Please include any blood thinning medications or aspirin?

Are you allergic to any medications or other substances?

Have you taken or currently taking medications for osteoporosis known as bisphosphonates for example Fosamax, Actonel, or Boniva?
____yes ____no List Medication _____

Circle if you have seen: an Orthodontist -had your bite adjusted- had any bite related treatment - TMJ Joint Surgery

Circle if you have seen any of the following healthcare professionals:

ENT, Neurologist, Chiropractor, or Massage Therapist

Do you snore, use a CPAP or have had a sleep study?

____yes ____no

Have you ever had radiation to the head and/or neck?

____yes ____no

Do you use tobacco products? ____yes ____no

Signature: _____ Date: _____



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HOW TO FIND US

Driving Directions to our Redmond Dental Office: We are conveniently located in the Redmond Town Center directly across from the Marriott Residence Inn. Redmond is at the east end of WA-520.

- From I-5: take exit 165B onto WA-520 East
 - Take the **West** Lake Sammamish Pkwy NE exit
 - Use any lane to turn left onto West Lake Sammamish Pkwy NE
 - Turn Right onto Leary Way
 - Turn right onto NE 76th St
 - At the traffic circle take the first exit onto 164th Ave NE
 - Turn left into the parking garage across from the Marriot Hotel and go to the top level
 - Smiles by Design is in building "A" to the right of Guitar Center (the main doors to the building are next to Versium).
- From I-405: take exit 14 onto WA-520 East
 - Take the **West** Lake Sammamish Pkwy NE exit
 - Use any lane to turn left onto West Lake Sammamish Pkwy NE
 - Turn Right onto Leary Way
 - Turn right onto NE 76th St
 - At the traffic circle take the first exit onto 164th Ave NE
 - Turn left into the parking garage across from the Marriot Hotel and go to the top level
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