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:

□ Same Day New Smile™ (All-on-four) □ Smile Makeover □ Metal-free Implants
□ Stem Cell Therapy □ TMJD Treatment □ Sedation Dentistry
□ Golden Ratio Rejuvenation™ (Non-surgical Facelift) □ 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
**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:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>AIDS/HIV</td>
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<tr>
<td>Anemia</td>
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<tr>
<td>Arthritis, Rheumatism</td>
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<td>Artificial Heart Valves</td>
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<td>Artificial Joints</td>
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<tr>
<td>Asthma</td>
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<td>Bleeding abnormally, with extractions or surgery</td>
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<td>Blood Disease</td>
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<td>Cancer</td>
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<td>Chemotherapy</td>
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<td>Circulatory Problems</td>
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<tr>
<td>Cortisone Treatments</td>
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<tr>
<td>Cough, persistent</td>
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<tr>
<td>Diabetes</td>
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<td>Epilepsy</td>
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<td>Fainting or dizziness</td>
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<td>Glaucoma</td>
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<tr>
<td>Heart Lesions</td>
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</tbody>
</table>

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: ________________________________
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
  o Take the **West** Lake Sammamish Pkwy NE exit
  o Use any lane to turn left onto West Lake Sammamish Pkwy NE
  o Turn Right onto Leary Way
  o Turn right onto NE 76th St
  o At the traffic circle take the first exit onto 164th Ave NE
  o Turn left into the parking garage across from the Marriot Hotel and go to the top level
  o 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
  o Take the **West** Lake Sammamish Pkwy NE exit
  o Use any lane to turn left onto West Lake Sammamish Pkwy NE
  o Turn Right onto Leary Way
  o Turn right onto NE 76th St
  o At the traffic circle take the first exit onto 164th Ave NE
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