

**TO THE PATIENT: PLEASE COMPLETELY FILL OUT SECTIONS 1, 2 & 3, SIGN AND DATE WHERE INDICATED.**

**Patient Information**

**SECTION 1**

Date: \_\_\_\_\_

Name: \_\_\_\_\_  Married  Single  Minor  Male  Female  
Last First M

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Drivers License Number: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt # City State Zip

E-Mail Address \_\_\_\_\_ Phone – Home: \_\_\_\_\_

Phone – Work: \_\_\_\_\_ Ext. \_\_\_\_\_ Time to Call: \_\_\_\_\_ Cell: \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation/Position \_\_\_\_\_

If Full time Student, School Name: \_\_\_\_\_ Grade \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_

Has any member of your family been treated in our office?  Yes  No Local # \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Insured Information**

**Father**  **Husband**

\_\_\_\_\_  
Last First M

\_\_\_\_\_  
Street City State Zip

\_\_\_\_\_  
Home # Work #

\_\_\_\_\_  
Birth Date (Mo/Day/Year) SS#

\_\_\_\_\_  
Employer Drivers License #

\_\_\_\_\_  
Dental Insurance Co. Group #

**Mother**  **Wife**

\_\_\_\_\_  
Last First M

\_\_\_\_\_  
Street City State Zip

\_\_\_\_\_  
Home # Work #

\_\_\_\_\_  
Birth Date (Mo/Day/Year) SS#

\_\_\_\_\_  
Employer Drivers License #

\_\_\_\_\_  
Dental Insurance Co. Group #

**Emergency Information**

Outside of Immediate Family/Household

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Telephone # \_\_\_\_\_

**Responsible Party**

Responsible party currently is a patient of record at this office  Yes  No

**Method of Payment:**  
 Patients will be expected to pay for services when treatment is rendered.  
 Visa/MasterCard are accepted.  
 I wish to discuss interest free financing with Care Credit

If you have insurance, we will help you to determine the coverage you have available. We ask that you assign your insurance benefits to us. Professional care is provided **to you, our patient, and not to an insurance company**. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will help in every way we can in filing your claim and in handling insurance questions from our office on your behalf. However, insurance balances 60 days and over are **due in full from the patient**.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I realize a responsible adult (parent or guardian) must remain in the office while treating a minor.

In connection with dental services which I am receiving, I consent that photographs, audio, and/or video recording may be taken of me for the explicit use of dental research, education, training or science; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name. I waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, or other showing of the photographs/video tape regardless of whether such use of said photographs/video tape is commercial, institutional or private sponsorship, and irrespective of whether any fee or charge is received.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_  
 Adult Patient  Father  Husband  Mother  Wife  Guardian

## SECTION 2

### Medical History

**Yes    No**

Are you under a physician's care now? Why? Who? \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Have you ever been hospitalized or had an operation? Describe \_\_\_\_\_

Have you ever had a serious injury to your head or neck? Describe \_\_\_\_\_

Are you taking any medications, pills or drugs? (Include illegal/recreational drugs) What? \_\_\_\_\_

Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)? \_\_\_\_\_

Are you on a special diet? Describe \_\_\_\_\_

Are you allergic to any medications or substances? Please check box for allergic reaction below \_\_\_\_\_

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex Rubber  Other \_\_\_\_\_

**Women** (Please check):  Pregnant/trying to get pregnant  Nursing  Taking oral contraceptives  Osteoporosis  
Describe \_\_\_\_\_

**Do you have or have you ever had any of the following:**

**(\*If yes to any of the \* starred conditions, please call prior to your appointment...premedicatons may be required)**

	Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur*	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Bleeding Problems)	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker*	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery*	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A & C (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (Serum)	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use/Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
						Seizure	<input type="checkbox"/>	<input type="checkbox"/>
						Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
						Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
						Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
						Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
						Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
						Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>
						Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
						Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
						Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>
						Artificial Joints*	<input type="checkbox"/>	<input type="checkbox"/>
						Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
						AIDS*	<input type="checkbox"/>	<input type="checkbox"/>
						HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
						Herpes (Cold Sore)	<input type="checkbox"/>	<input type="checkbox"/>
						Drug Addiction/Use	<input type="checkbox"/>	<input type="checkbox"/>
						Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
						Snoring/ Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had any other serious illness not checked above? Describe \_\_\_\_\_

Do you wish to talk to the dentist privately about any problem? \_\_\_\_\_

*To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail I will inform the doctor promptly of any medications legal or illegal, prescription or non-prescription that I am taking. In Accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a NOTICE that describes how medical information about you may be used and disclosed and how you can get access to this information is posted in the RECEPTION room. Should I desire to have a printed copy of this NOTICE, I will check the following box and notify the RECEPTIONIST:  **I DO WANT A COPY OF 'NOTICE'**  **I DO NOT WANT A COPY OF 'NOTICE'***

Date: \_\_\_\_\_

Adult Patient  Father  Husband  Mother  Wife  Guardian

Reviewed by Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_

Medical History Update

<u>Date</u>	<u>Comments</u>	<u>Signature</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

## SECTION 3

KMGCH007 Revised 8-15-08

### Dental History (Patient To Fill Out Completely)

Primary reason for this dental appointment:  Examination  Emergency  Consultation

Date of your last dental visit \_\_\_\_\_ For what? \_\_\_\_\_

Date of your last dental cleaning \_\_\_\_\_ **Yes No**

Do you have a specific dental problem? Describe \_\_\_\_\_

What kind of dental procedures have you had done in the past? \_\_\_\_\_

Do you have any sensitive teeth? \_\_\_\_\_

Have you ever had a toothache or a fractured tooth? \_\_\_\_\_

Have you ever had periodontal problems? \_\_\_\_\_

Do you like your smile? Why? \_\_\_\_\_

Does food catch between your teeth or do you have areas that are difficult to floss? \_\_\_\_\_

Does loss of teeth tend to run in your family? \_\_\_\_\_

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_

Have you ever had Orthodontics (Braces)? \_\_\_\_\_

Have your past experiences in a dental office always been positive? \_\_\_\_\_

Do you smoke or chew tobacco? Any sores or growths in your mouth? Describe \_\_\_\_\_

Name of previous dentist (Optional) \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

Have you noticed spots or stains on your teeth that concern you? \_\_\_\_\_

Anything else that concerns you about the appearance of your teeth? \_\_\_\_\_

If you could change anything about your smile, what would you change? \_\_\_\_\_

\_\_\_\_\_

Do you have a denture or partial denture?  No  Yes How old are they? \_\_\_\_\_ How do you like them? \_\_\_\_\_

\_\_\_\_\_

Have you ever required Nitrous Oxide (Laughing Gas) or sedatives for your dental treatment? \_\_\_\_\_

### Check Your Level of Bravery: Don't Worry, We Cater To Cowards



## SECTION 4

### Initial Clinical Exam (I.C.E.)

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Stains:  No  Lt  Mod  Hvy

Calculus:  No  Lt  Mod  Hvy

Plaque:  No  Lt  Mod  Hvy

Bleeding:  No  Lt  Mod  Hvy

TMJ:  Asymptomatic  Symptoms: \_\_\_\_\_

Homecare: Brushing: \_\_\_\_\_ x/day Floss: \_\_\_\_\_ x/week

Perio Diag:  Normal  Gingivitis  Early Perio  Mod Perio  Adv Perio  Maint

Instructions:  Brush  Floss  Perio Aid  Other: \_\_\_\_\_

Ortho: Occlusal Type:  CLI  CLII  CL III

#### Soft Tissue Screening

Cancer Exam:  Normal  Lesion: Describe \_\_\_\_\_

*See dental history for smoking history*

	Normal	Abnormal	
Lips	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucosa	<input type="checkbox"/>	<input type="checkbox"/>	_____
Palate	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tongue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Floor	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	_____

Upper Right	Upper Anterior	Upper Left
Lower Right	Lower Anterior	Lower Left

Maximum Pocket Depth  
Per Sextant in mm

Recall: \_\_\_\_\_ Months Doctor's Signature: Reviewed by: \_\_\_\_\_