

# KVINSLAND DENTISTRY

REFERRED BY \_\_\_\_\_ DATE \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ M  F   
 SINGLE  MARRIED  DIVORCED  SEPARATED  WIDOWED

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ RES. PHONE \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

E-MAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_

PREVIOUS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

S.S.N. \_\_\_\_\_ EMPLOYER/OCCUPATION \_\_\_\_\_ BUS. PHONE \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ EMPLOYER/OCCUPATION \_\_\_\_\_ BUS. PHONE \_\_\_\_\_

SPOUSE'S S.S.N. \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ NEAREST FRIEND/RELATIVE \_\_\_\_\_ RES. PHONE \_\_\_\_\_

PRIMARY INS. \_\_\_\_\_ GROUP # \_\_\_\_\_

SECONDARY INS. \_\_\_\_\_ GROUP # \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCT. \_\_\_\_\_

ADDRESS \_\_\_\_\_

CHIEF ORAL COMPLAINT \_\_\_\_\_

DATE OF LAST EXAM \_\_\_\_\_ ANY PREVIOUS MAJOR DENTAL TREATMENT? \_\_\_\_\_ WHEN \_\_\_\_\_

### DENTAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING? INDICATE WITH A

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Concerns w/appearance of teeth                   | <input type="checkbox"/> Removable dental appliance         | <input type="checkbox"/> Complications from extractions |
| <input type="checkbox"/> Teeth sensitive to cold, hot, sweets or pressure | <input type="checkbox"/> Swelling or lumps in mouth         | <input type="checkbox"/> Periodontal treatment          |
| <input type="checkbox"/> Bleeding gums                                    | <input type="checkbox"/> Unpleasant Taste                   | <input type="checkbox"/> Orthodontic treatment          |
| <input type="checkbox"/> Food impaction                                   | <input type="checkbox"/> Pain around ear                    | <input type="checkbox"/> Mouth Breathing                |
| <input type="checkbox"/> Clenching or grinding                            | <input type="checkbox"/> Unusual sounds in ear while eating | <input type="checkbox"/> Unpleasant dental experience   |
|   | <input type="checkbox"/> Bad Breath                         | <input type="checkbox"/> Other                          |

### HEALTH QUESTIONNAIRE

ARE YOU PRESENTLY ILL OR UNDER THE CARE OF A PHYSICIAN? \_\_\_\_\_  YES  NO

IF YES PLEASE DESCRIBE: \_\_\_\_\_

NAME OF PHYSICIAN \_\_\_\_\_ PHONE: \_\_\_\_\_ DATE OF LAST PHYSICAL \_\_\_\_\_

**DO YOU HAVE, OR HAVE YOU HAD:** (Please check at the RIGHT of each item)

(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW
Allergies to antibiotics, or other medications? Please list:				Epilepsy or Seizures				Ulcers			
				Fainting or Dizziness				Kidney problems			
				Stroke				Venereal disease			
Heart problems or Angina				Glaucoma				Diabetes			
High blood pressure				Cold sores (Herpes)				Thyroid disease			
Rheumatic fever				Persistent cough				HIV positive/AIDS			
Heart murmur				Emphysema				Arthritis			
Heart surgery				Tuberculosis				Painful joints (incl. jaw)			
Prosthetic heart valve(s)				Asthma				Prosthetic joint(s)			
Pacemaker				Sinus problems				Drug addiction			
Hepatitis type: _____				Anemia				Alcoholism			
Liver disease				Hemophilia				Psychiatric care emotional problems			
Yellow jaundice				Bruise or bleed easily				Cancer/radiation therapy			

Do you use any tobacco products? Yes  No  Describe: \_\_\_\_\_

Describe any current medication, condition or medical treatment not listed above (including aspirin, BC pill, hormone therapy) \_\_\_\_\_

REVISED INFORMATION/COMMENTS: \_\_\_\_\_

I acknowledge that I am financially responsible for all charges whether or not paid by insurance. If it becomes necessary to effect collections of balance due, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

Signature \_\_\_\_\_ Date \_\_\_\_\_