Welcome

Kenwood Advanced Dentistry

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us we will be happy to help.

Patient Information (CONFIDENTIAL)

Name_____ Birthdate_____ Primary Phone_____

Address_____ City_____ State/Prov._____ Zip_____

Check Appropriate Box ☐Minor ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐Separated

If Student, Name of School / College_____ F.T.☐ P.T. ☐ City_____ State/Prov_____

Patient's or Parent's Employer_____ Work Phone _____

Business Address_____ City_____ State/Prov. _____ Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____

Drivers License # _____ Birthdate _____Financial Institution_____

Employer_____ Work Phone_____ SSN#_____

Is this Person Currently a Patient in our Office? ☐Yes ☐No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. ☐Cash ☐Personal Check ☐Credit Card ☐VISA ☐MasterCard ☐I wish to discuss the office's payment policy.

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SSN _____ Date Employed _____

Name of Employer _____ Union or Local #_____ Work Phone _____

Address of Employer _____ City_____ State/Prov_____ Zip_____

Insurance Company _____ Group # _____ Policy ID#_____

Ins. Co. Address _____ City_____ State/Prov_____ Zip_____

How much is your deductible? _____ How Much Have You Used? _____ Max Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐Yes ☐No IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SSN _____ Date Employed _____

Name of Employer _____ Union or Local #_____ Work Phone _____

Address of Employer _____ City_____ State/Prov_____ Zip_____

Insurance Company _____ Group # _____ Policy ID#_____

Ins. Co. Address _____ City_____ State/Prov_____ Zip_____

How much is your deductible? _____ How Much Have You Used? _____ Max Annual Benefit _____

Patient Medial History

Physician_____ Office Phone _____ Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____ _____	☐	☐
3. Are you taking any medication(s) Including Non-prescription medicines? If yes, what medication(s) are you Taking? _____ _____	☐	☐
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐

8. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocain).....	☐	☐
Penicillin or other Antibiotics.....	☐	☐
Sulfa Drugs.....	☐	☐
Barbiturates.....	☐	☐
Sedatives.....	☐	☐
Iodine.....	☐	☐
Aspirin.....	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber.....	☐	☐
Other (Please List)_____		
9. Women Only:		
a) Are you pregnant or thing you may be pregnant	☐	☐
b) Are you nursing?.....	☐	☐
c) Are you taking oral contraceptives?.....	☐	☐

7. Do you have or have had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure.....	☐	☐	Heart Disease.....	☐	☐	Chest Pains.....	☐	☐
Heart Attack.....	☐	☐	Cardiac Pacemaker.....	☐	☐	Easily Winded.....	☐	☐
Rheumatic Fever.....	☐	☐	Heart Murmur.....	☐	☐	Stroke.....	☐	☐
Swollen Ankles.....	☐	☐	Angina.....	☐	☐	Hay Fever / Allergies.....	☐	☐
Fainting/Seizures.....	☐	☐	Frequently Tired.....	☐	☐	Tuberculosis.....	☐	☐
Asthma.....	☐	☐	Anemia.....	☐	☐	Radiation Therapy.....	☐	☐
Low Blood Pressure.....	☐	☐	Emphysema.....	☐	☐	Glaucoma.....	☐	☐
Epilepsy / Convulsions.....	☐	☐	Cancer.....	☐	☐	Recent Weight Loss.....	☐	☐
Leukemia.....	☐	☐	Arthritis.....	☐	☐	Liver Disease.....	☐	☐
Diabetes.....	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble.....	☐	☐
Kidney Disorders.....	☐	☐	Hepatitis / Jaundice.....	☐	☐	Respiratory Problems.....	☐	☐
AIDS or HIV infection.....	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Value Prolapse.....	☐	☐
Thyroid Problem.....	☐	☐	Stomach Troubles / Ulcers.....	☐	☐	Other.....	☐	☐

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?.....	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?.....	☐	☐
7. Have you ever experienced any of the following problems In your jaw?		
Clicking?.....	☐	☐
Pain (joint, ear, side of face)?.....	☐	☐
Difficulty in opening or closing?.....	☐	☐
Difficulty in chewing?.....	☐	☐
8. Do you have frequent headaches?.....	☐	☐
9. Do you clinch or grind your teeth?.....	☐	☐
10. Do you bite your lips or cheeks frequently?.....	☐	☐
11. Have you ever had any difficult extractions in the past?.....	☐	☐
12. Have you ever had any prolonged bleeding following extractions?.....	☐	☐
13. Have you had any orthodontic treatment?.....	☐	☐
14. Do you wear dentures or partials?.....	☐	☐
If yes, date of placement_____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth?	☐	☐
16. Do you like your smile?.....	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentists or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent if minor)

Doctor's Comments_____

_____

_____ Signature_____ Date _____