

Patient Medical History

Physician	Office Phone	Date of Last Exam
Yes	No	
1. Are you under medical treatment now?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicines?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medicine(s) are you taking? _____		
4. Have you ever taken Phen-Fen/Redux?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use tobacco?_____	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you use controlled substances?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have or have had any of the following?	Yes	No

- High Blood Pressure.....
- Heart Attack.....
- Rheumatic Fever.....
- Swollen Ankles.....
- Fainting / Seizures.....
- Asthma.....
- Low Blood Pressure.....
- Epilepsy / Convulsions.....
- Leukemia.....
- Diabetes.....
- Kidney Disorders.....
- AIDS or HIV Infection.....
- Thyroid Problem.....
- Heart Disease.....
- Cardiac Pacemaker.....
- Heart Murmur.....
- Angina.....
- Frequently Tired.....
- Anemia.....
- Emphysema.....
- Cancer.....
- Arthritis.....
- Joint Replacement or Implant.....
- Hepatitis / Jaundice.....
- Sexually Transmitted Disease.....
- Stomach Troubles / Ulcers.....
- Stroke.....
- Hay Fever / Allergies.....
- Tuberculosis.....
- Radiation Therapy.....
- Glaucoma.....
- Recent Weight Loss.....
- Liver Disease.....
- Heart Trouble.....
- Respiratory Problems.....
- Mitral Valve Prolapse.....
- 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?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you clinch or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>

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 _____

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 _____	Address _____	Birthdate _____	Home Phone _____	Patient # _____				
Address _____	City _____	State/Prov. _____	Zip _____	Soc. Sec. # _____				
Check Appropriate Box:	<input type="checkbox"/> Minor	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated	Full	Part
If Student, Name of School / College _____	City _____	State/Prov. _____	Time	□ Time	Work Phone _____	City _____	State/Prov. _____	Zip _____
Patient's or Parent's Employer _____	City _____	State/Prov. _____	Zip _____	Spouse or Parent's Name _____	Employer _____	City _____	State/Prov. _____	Zip _____
Business Address _____	City _____	State/Prov. _____	Zip _____	Whom May We Thank for Referring You? _____	Person to Contact in Case of Emergency _____	Phone _____	Phone _____	Phone _____
Drivers License # _____	Birthdate _____	Financial Institution _____	SSN# _____	Employer _____	Work Phone _____	Employer _____	Relationship to Patient _____	Relationship to Patient _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Date Employed _____	Date Employed _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Work Phone _____	Work Phone _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	City _____	City _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	State/Prov. _____	State/Prov. _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Zip _____	Zip _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Policy ID# _____	Policy ID# _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Ins. Co. Address _____	Ins. Co. Address _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	City _____	City _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	State/Prov. _____	State/Prov. _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Zip _____	Zip _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Max Annual Benefit _____	Max Annual Benefit _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	How Much Have You Used? _____	How Much Have You Used? _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	DO YOU HAVE ANY ADDITIONAL INSURANCE? _____	DO YOU HAVE ANY ADDITIONAL INSURANCE? _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	IF YES, COMPLETE THE FOLLOWING:	
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Relationship to Patient _____	Relationship to Patient _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Date Employed _____	Date Employed _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Work Phone _____	Work Phone _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	City _____	City _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	State/Prov. _____	State/Prov. _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Zip _____	Zip _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Policy ID# _____	Policy ID# _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Ins. Co. Address _____	Ins. Co. Address _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	City _____	City _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	State/Prov. _____	State/Prov. _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Zip _____	Zip _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Max Annual Benefit _____	Max Annual Benefit _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	How Much Have You Used? _____	How Much Have You Used? _____
Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Address _____	Over Please _____	Over Please _____

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 _____	Birthdate _____	Social Security # _____	Union or Local # _____	Work Phone _____	Relationship to Patient _____	Date Employed _____	Relationship to Patient _____
Name of Employer _____	Address of Employer _____	City _____	State/Prov. _____	Zip _____	City _____	State/Prov. _____	Zip _____
Insurance Company _____	Group # _____	City _____	State/Prov. _____	Zip _____	City _____	State/Prov. _____	Zip _____
Ins. Co. Address _____	How much is your Deductible? _____	How Much Have You Used? _____	Max Annual Benefit _____	Max Annual Benefit _____	How much is your Deductible? _____	How Much Have You Used? _____	Max Annual Benefit _____
Name of Insured _____	Birthdate _____	Social Security # _____	Union or Local # _____	Work Phone _____	Relationship to Patient _____	Date Employed _____	Relationship to Patient _____
Name of Employer _____	Address of Employer _____	City _____	State/Prov. _____	Zip _____	City _____	State/Prov. _____	Zip _____
Insurance Company _____	Group # _____	City _____	State/Prov. _____	Zip _____	City _____	State/Prov. _____	Zip _____
Ins. Co. Address _____	How much is your Deductible? _____	How Much Have You Used? _____	Max Annual Benefit _____	Max Annual Benefit _____	How much is your Deductible? _____	How Much Have You Used? _____	Max Annual Benefit _____