Dental Health Center

Patient Name: ________________________ ____________ ____ Today's Date: _____________
Last **First** **MI**

Male __ Female __ Married ___ Single ___ Child ___ Other ___

I prefer to be called _________________

Social Security # _______ - ____ - _______ Birth Date: ____ / ____ / ____ Your Age: ________

Home Address: ____ Apt #: ______________

________________________________ ________________ ______________
City **State** **Zip**

Telephone # Home: _____________________ **Cell:** __________________ **E-Mail:** ______________________

Your Employer: ___________________________ **Work Address:** ________________________________

____

Work Phone # ___________________**Ext:** ______ ________________________________
City **State** **Zip**

Referral Information

Can we thank someone for referring you?
Family member ___________________
Coworker _______________________
Friend _________________________
Doctor Referral ___________________

Or did you find us on your own?
_____ Our Website / Dr Oogle
_____ Radio
_____ News letter
_____ Other

Dental Insurance information

Insurance Company: _____________________________________ Group #: ________________

Address: ____________________________________ Phone #: (_____) _____- ______

_________________________ _________ __________
City State Zip

Name of Insured: _______________________ **Social Security #** _____-____-_____ **Date of Birth** ____ / ____ / ____

Insured Employer Name: ______________________________________ Relationship to Insured __________

Address: ______________________________________

____

Work Phone # (____) ______ - ________ Ext: _____ (if different from above)

Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Dr. Timothy M. Kelly of the group insurance benefits otherwise payable to me.

____ **Date:** _________________
Signature of patient, parent or guardian

Emergency Contact Information

Contact Name: _____________________ Relationship to you? ________________________

Phone # (____) ____ - _______

Person Responsible for All Account Balances: ____
Print Name

Social Security # _____________________ **Signature** ____
If different from above

Health History

Name ____ Date ___________________
Date of last health care exam: _________________________ What was this exam for? ________________________
Have you been hospitalized in the last 5 years? (Please circle) **No** **Yes**
If yes, reason: ____
Are you currently receiving care? **No** **Yes** If yes, nature of care: ___________________________
Please list all the names and phone numbers of the **Physicians** who are currently providing you care:

1. ____
2. ____
3. ____
4. ____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis/Mental Illness	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes			

Are you required to Pre-Medicate before dental treatment? No Yes

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
If yes, what is it usually: S _____ / D _____

Are you allergic or have you had a reaction to:

a. Local anesthetics ………………………………………………………... No Yes
b. Penicillin or other antibiotics …………………………………………… No Yes
c. Aspirin ….………………..…………………………………………... No Yes
d. Codeine, valium or other sedatives……………………………………..… No Yes
e. Other ____

Are you a smoker? No Yes
If so, how much do you smoke per day? _________________

Please list any medications you are currently taking:

1. ______________________________________ For ___________________________________
2. ______________________________________ For ___________________________________
3. ______________________________________ For ___________________________________
4. ______________________________________ For ___________________________________
5. ______________________________________ For ___________________________________

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Comments on patient interview concerning medical history:

____

____

____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

____________________________ ____________________________ ________________

Patient** (Print Name)* ***Patient Signature *Date*

____________________________ ________________

Doctor Signature *Date*

XXXXXXXXXXXXXXXXXXXXXXX Do Not Write Below Line XXXXXXXXXXXXXXXXXXXXXXXX

INFORMATION UPDATE

Have you had a change in your health since your last visit? No Yes

Heart (Surgery, Disease, Attack)	No	Yes	Hepatitis, Any Form	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Rheumatic Fever	No	Yes
Joint Replacement	No	Yes	H.I.V. Infection/AIDS	No	Yes
Taken Fen-phen or other diet pills	No	Yes			

Have you had a visit to a physician since your last dental visit? No / Yes

Whom and for what? ____

____

____

Women: Are you pregnant? No / Yes Are you a nursing mother? No / Yes

Please list any medications you are currently taking:

1. ______________________________ For: ______________________________
2. ______________________________ For: ______________________________
3. ______________________________ For: ______________________________
4. ______________________________ For: ______________________________

Do you have any **allergies?** No / Yes List: ____

Signature ____ Date ____________________

Signature ____ Date ____________________

Signature ____ Date ____________________

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Dental Health Registration

Name ______________________________ Date ______________

Correct answers to the following questions will allow Dr. Kelly to treat you on a individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? No Yes
   If yes explain ______________________________
2. Have you ever had any serious trouble associated with previous dental care? No Yes
3. Does dental treatment make you nervous? No Yes
4. When was your last dental examination or treatment? Date ______________

Do you currently have or ever experienced any of the following

Bleeding gums	No	Yes	Loose teeth	No	Yes
Unpleasant taste / bad breath	No	Yes	Teeth sensitive to hot	No	Yes
Burning tongue or lips	No	Yes	Teeth sensitive to cold	No	Yes
Fever blisters lips / mouth	No	Yes	Teeth sensitive to sweets	No	Yes
Orthodontic treatment (braces)	No	Yes	Teeth sensitive when chewing	No	Yes
Do you bite your cheeks or lips	No	Yes	Food impaction between teeth	No	Yes

Have you ever been diagnosed with a "TMJ" problem?

Does your jaw pop or click when you open your mouth?	No	Yes
Are you aware of any clenching or grinding of your teeth?	No	Yes
Do you have pain or difficulty opening your mouth wide?	No	Yes
Do you have a history of headaches or neck aches?	No	Yes

1. What is most important to you about your dental health? ______________________________
   ____
2. What do you fear the most about receiving dental care? ______________________________
   ____
3. Are you interested in **Sedation** "Anxiety Free" dentistry? No Yes
4. Are you satisfied with the appearance of your teeth? ______________________________
   ____
5. Do you wish to keep your teeth for a lifetime? ______________________________
6. Has the appearance of your teeth changed dramatically over the last 10 years? No Yes

If you could change your teeth with a magic wand what would you want for yourself?

____
____
____