"Welcome to our practice..."

We believe people should keep their teeth for a lifetime. Our goal is to bring you the best in dental care amidst a warm and friendly environment Your answers to the following questions are the first step in determining your immediate and long term dental care. Please add any comments you may have...the more we understand about your needs and concerns, the better we can care for you! Thank You!

Alicia K Kennedy, DDS

PATIENT INFORMATION

NAME _____ HOME PHONE _____
ADDRESS _____ CITY _____ ZIP _____
SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____ AGE _____ BIRTHDATE _____
EMAIL ADDRESS _____ CELL PHONE PAGER _____ OTHER _____
PREFERRED METHOD OF CONTACT ❑ OFFICE PHONE ❑ HOME PHONE ❑ E-MAIL ❑ OTHER _____
EMPLOYED BY _____ OCCUPATION _____ HOWLONG _____
EMPLOYER ADDRESS _____ BUSINESS PHONE _____
SPOUSE NAME _____ BIRTHDATE _____
NAME OF FRIEND OR RELATIVE TO NOTIFY IN CASE OF EMERGENCY _____ PHONE _____
ADDRESS _____ CITY _____ ZIP _____

RESPONSIBLE PARTY

NAME _____ HOME PHONE _____
ADDRESS _____ CITY _____ ZIP _____
SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____ AGE _____ BIRTHDATE _____
EMPLOYED BY _____ OCCUPATION _____ HOWLONG _____
EMPLOYER ADDRESS _____ BUSINESS PHONE _____

INSURANCE INFORMATION

DO YOU OR RESPONSIBLE PARTY HAVE DENTAL INSURANCE ❑ YES ❑ NO SECONDARY INSURANCE? ❑ YES ❑ NO
IF SO NAME OF PATIENT'S INSURED _____ EMPLOYER _____
SOCIAL SECURITY # OF INSURED _____ POLICY NUMBER _____
INSURANCE COMPANY _____ GROUP NUMBER _____

YOUR SPOUSE'S SOCIAL SECURITY # _____ EMPLOYER _____
INSURANCE COMPANY _____ POLICY NUMBER _____

It is our wish to assist in the preparation and completion of insurance forms. We ask, however, that the interested person complete the employee information on each form. Although financial responsibility rests with each patient we will be happy to submit insurance forms on your behalf.

WHO MAY WE THANK FOR REFERRING YOU TO US

NAME _____

CONSENT

This undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.

_____ _____ _____
Signature of patient (if minor - parent or legal guardian) I have received a copy of the Dental Materials Fact Sheet version issued 2004. (Please sign on line above) Date

CONFIDENTIAL DENTAL HISTORY — FOR OFFICE USE ONLY

☐ Dr.
☐ Mr.
☐ Mrs.
☐ Miss
☐ Ms. _____ Date _____
Last First Middle

Your answers to this dental history questionnaire will help us to understand your specific dental problems, so that we may more effectively treat you with consideration for your individual needs.

Previous Dentist _____ Specialty _____

Period of Treatment _____ Date of Last Visit _____

Address _____
Number Street City State Zip Code (Area Code) Phone

Other Dentist _____ Specialty _____

Period of Treatment _____ Date of Last Visit _____

Address _____
Number Street City State Zip Code (Area Code) Phone

Last comprehensive full mouth x-ray _____

Last comprehensive dental exam _____

Please check YES or NO.

1. Are you presently in pain? ☐ YES ☐ NO
   ☐ Teeth ☐ Jaw ☐ Face
   ☐ Gums ☐ Other _____
2. Is .any part of your mouth sensitive to the following: ☐ YES ☐ NO
   ☐ Hot ☐ Cold ☐ Pressure
   ☐ Sweet ☐ Sour ☐ Other _____
3. Do you have a burning Sensation in your mouth? ☐ YES ☐ NO
4. Are you troubled with dryness in your mouth? ☐ YES ☐ NO
5. Do you have any pain or soreness around your eyes, ears or other parts of your face? ☐ YES ☐ NO
6. Do you have chronic, headaches? ☐ YES ☐ NO
7. Do you have chronic neckaches? ☐ YES ☐ NO
8. Have you ever had periodontal treatment or gum surgery? ☐ YES ☐ NO
   If YES, when? _____ By whom? _____
9. Have you ever been informed that you have gum problems? ☐ YES ☐ NO
   If YES, when? _____ By whom? _____
10. Do your gums bleed when you brush your teeth? ☐ YES ☐ NO
11. Does food catch between your teeth? ☐ YES ☐ NO

12. Are you aware of a bad taste or odor in your mouth? ☐ YES ☐ NO

13. Please indicate which items you use daily.
☐ Hard-bristle toothbrush ☐ Proxi-brush ☐ Water spray
☐ Soft-bristle toothbrush ☐ Rubber tip ☐ Stimudents or toothpicks
☐ Electric toothbrush ☐ Dental floss ☐ Other_____

14. Are you aware of any growths or swellings in your mouth? ☐ YES ☐ NO
If YES, where are they located and how long have they existed? _____
_____

15. Do you have frequent cold sores, canker sores or fever blisters on your gums, cheeks or lips? ☐ YES ☐ NO
If YES, how often? _____

16. Are you aware of your jaw clicking, popping or making grating-like noises? ☐ YES ☐ NO
If YES, when? _____

17. Do your jaw muscles feel tired, stiff or painful? ☐ YES ☐ NO

18. Are you aware of clenching your teeth during the day? ☐ YES ☐ NO
If YES, how often? _____

19. Have you ever been, told you grind your teeth during sleep? ☐ YES ☐ NO
If YES, how often? _____

20. Is there anything you'd like to change regarding the appearance of your teeth? ☐ YES ☐ NO
If YES, what would you most like to. change? _____
_____

21. Are you interested in whitening your teeth? ☐ YES ☐ NO

22. Do you wear a removable denture or appliance? ☐ YES ☐ NO
If YES, when do you wear it? _____

23. Are you frustrated by needing constant dental repair because of your active dental disease? ☐ YES ☐ NO

24. Are you anxious about dental treatment? ☐ YES ☐ NO

25. Would you like sedation during your appointment?. ☐ YES ☐ NO

26. Do you want to learn to control your dental disease to preserve your teeth and oral health? ☐ YES ☐ NO

27. Have you had oral surgery? ☐ YES ☐ NO
If YES, when? _____ By whom? _____

28. Have you had orthodontic treatment? ☐ YES ☐ NO
If YES, when? _____ By whom? _____

29. Have you ever had an adverse reaction to a local anesthetic? ☐ YES ☐ NO
If YES, please explain _____

30. Have you ever had an adverse reaction to any material used in dentistry? ☐ YES ☐ NO
If YES, please explain_____

31. Do you have any disease or condition which was not addressed above that you feel is important for us to know? ☐ YES ☐ NO
If YES, please explain _____

Signature _____ Date _____

CONFIDENTIAL MEDICAL HISTORY — FOR OFFICE USE ONLY

☐ Dr.
☐ Mr.
☐ Mrs.
☐ Miss
☐ Ms. _____ Date _____
Last First Middle

The thoroughness of this medical history is designed for your safety, and complete answers will assist us in treating you with consideration for your special needs.

Family Physician _____ Date of last visit _____
Specialty _____
Address _____
Number, Street, City, State, Zip Code, Area Code, Phone

Additional Physician _____ Date of last visit _____
Specialty _____
Address _____
Number, Street, City, State, Zip Code, Area Code, Phone

Please check YES or NO.

1. Do you have a current medical problem? ☐ YES ☐ NO
   If YES, please describe _____
2. Are you currently under the care of a physician? ☐ YES ☐ NO
   If YES, please list _____
3. Have you been hospitalized or had a serious illness within the past 5 years? ☐ YES ☐ NO
   If YES, please describe _____
4. Do you have heart trouble or any form of cardiovascular disease? ☐ YES ☐ NO
   - ☐ Angina (chest pains) Frequency _____
   - ☐ Heart attack (date) _____
   - ☐ Heart Surgery _____
     - ☐ Pacemaker
     - ☐ Bypass
     - ☐ Prosthetic heart valve
   - Stroke (date) _____
   - ☐ Rheumatic fever (date) _____
   - ☐ Heart murmur
   - ☐ High blood pressure
   - ☐ Congenital heart lesions
   - ☐ Arthrosclerosis
   - ☐ Mitral valve prolapsed
   - ☐ Other _____
5. Do you have diabetes? ☐ YES ☐ NO
   If YES, how is it controlled? _____
6. Do you have hypoglycemia? ☐ YES ☐ NO
   If YES, how is it controlled? _____
7. Do you have kidney disease? ☐ YES ☐ NO
8. Have you ever had hepatitis? (date) _____ ☐ YES ☐ NO
   ☐ Type A Infectious (Food) ☐ Type B Serum (Blood) ☐ Type C
   ☐ Unknown (Explain) _____
9. Have you ever had liver disease or jaundice? (date) _____ ☐ YES ☐ NO
10. Do you have any blood disease? ☐ YES ☐ NO
    ☐ Anemia ☐ AIDS or positive test ☐ Leukemia
    ☐ Venereal disease ☐ Other _____
11. Do you have any problems with excess bleeding? ☐ YES ☐ NO
    If YES, please explain _____
12. Do you have stomach or intestinal ulcers? ☐ YES ☐ NO
13. Have you ever had tuberculosis? (date) _____ ☐ YES ☐ NO

14. Do you have emphysema, asthma or breathing problems? ☐ YES ☐ NO

15. Do you have any form of arthritis? ☐ YES ☐ NO
☐ Rheumatoid Arthritis ☐ Gout/Gouty Arthritis
☐ Osteoarthritis ☐ Other _____
Which joints are involved?_____

16. Have you ever had a hip or other joint replacement? ☐ YES ☐ NO

17. Have you ever had any injury, pain or soreness from your jaw joint? (TMJ dysfunction) ☐ YES ☐ NO

18. Have you ever had any chronic head, neck or back pain problems? ☐ YES ☐ NO

19. Have you ever suffered trauma to your head or neck, such as in a car accident? ☐ YES ☐ NO
If YES, please describe_____

20. Do you have fainting spells, convulsions or epilepsy? ☐ YES ☐ NO

21. Have you had surgery, radiation or other treatment for a tumor or growth? ☐ YES ☐ NO
If YES, please describe_____

22. Do you have glaucoma? ☐ YES ☐ NO
☐ Right eye ☐ Left eye ☐ Both eyes

23. Is your diet medically prescribed? ☐ YES ☐ NO
If YES, please explain_____

24. Are you taking any calcium supplementation? ☐ YES ☐ NO

25. Have you ever taken Phen-Fen? ☐ YES ☐ NO
If YES, you may have sustained heart valve damage. This can only be assessed by your physician. We recommend you have an evaluation, for this may require prophylactic antibiotics before dental treatment.

26. Have you ever had a part of your body pierced? ☐ YES ☐ NO
If YES, please describe location_____ (date)_____

27. Have you ever had any elective cosmetic surgery or implants? ☐ YES ☐ NO
If YES, please describe_____ (date)_____

28. Have you ever suffered from any sleep disorders? ☐ YES ☐ NO

29. How long does it take for you to fall asleep?
5-10 Min ☐ 20-30 Min ☐ 30 Min or More ☐

30. Do you awaken frequently at night? ☐ YES ☐ NO
0-1 ☐ 2-3 ☐ Mors Than 3 ☐

31. When you awaken in the morning do you feel tired? ☐ YES ☐ NO

FOR WOMEN:

* 32. Are you pregnant? (Expected delivery date) _____ ☐ YES ☐ NO

* 33. Do you have a history of previous miscarriages? ☐ YES ☐ NO

* 34. Have you reached menopause? ☐ YES ☐ NO
If YES, what hormones are you taking, if any? _____

35. Are you allergic to or have you had any unusual reaction to any of the following medications? ☐ YES ☐ NO

- ☐ Penicillin
- ☐ Erythromycin
- ☐ Sulfa Drugs
- ☐ Other Antibiotics _____
- ☐ Codeine
- ☐ Aspirin
- ☐ Other pain medications _____
- ☐ Any other drug allergies? _____
- ☐ Local anesthetics
  - ☐ Novocaine
  - ☐ Xylocaine
- ☐ Nitrous oxide
- ☐ Epinephrine
- ☐ Barbiturates
- ☐ Sleeping pills
- ☐ Latex allergy
- ☐ _____

36. Have you ever been advised not to take a particular medication? ☐ YES ☐ NO
if YES, please list _____

37. Have you ever been advised to take prophylactic Antibiotics before dental treatment? ☐ YES ☐ NO

38. Are you currently taking any medication? ☐ YES ☐ NO
Please indicate if you are taking any of the following medications:

- ☐ Heart Medication
- ☐ Blood Pressure Medication
- ☐ Nitroglycerine
- ☐ Inderal
- ☐ Antibiotics
- ☐ Sedatives
- ☐ Tranquilizers
- ☐ Pain Medication
- ☐ Cortisone (Steroids)
- ☐ Thyroid
- ☐ Birth Control Pills
- ☐ Other Medications.
- ☐ Herbal Supplements
- ☐ Vitamins

Name	Purpose	Frequency	Since

☐ Alcohol (_____) drinks per day

☐ Tobacco (_____) packs per day for approximately (_____) years

☐ "Recreational" drugs such as cocaine, marijuana, stimulants or depressants may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

_____

_____

39. Is there anything more you'd like to add? ☐ YES ☐ NO

_____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

Signature _____ Date _____