KAYSVILLE FAMILY DENTISTRY

Patient Information

Patient Name: _____ Date: ___/___/___
Last First MI (Preferred Name)

Gender: Male Female Family Status: Married Single Divorced Separated Widowed Minor

Birth Date: _____ Social Security #: _____ Email: _____

Phone (Home): _____(Work): _____(Cell): _____ Best time to call: _____

Address: _____
Street City State Zip Code

Emergency Contact: _____
Name Phone # Relationship to you

How do you prefer to be reminded of upcoming appointments? ____ Text or _____ Email

Referral Information

Whom may we thank for referring you to our practice? ☐ Insurance ☐ Social Media ☐ Internet ☐ Patient

Name of person, office, or other source referring you to our practice: _____

Insurance Subscriber Information

Subscriber Name: _____

Patient's Relationship to Subscriber: Self Spouse Child Other

Insurance Company Name _____

Subscriber Birth Date: _____ Subscriber Social Security #: _____

or Subscriber ID #_____ Group ID #: _____ Subscriber Employer: _____

Please bring your dental insurance card and driver's license to the front desk.

Certification: I certify that the answers to the health questions are correct to the best of my knowledge.

Authorized Signature:_____Date:_____.
Print Name:_____Relationship:_____.

Medical History

Primary Care Physician: _____
Name Phone #

Are you currently under the care of a physician? Yes No
If yes, what is the condition being treated? _____
Have you had any illnesses or surgeries we need to be aware of? Yes No
If yes, please explain: _____
Have you been hospitalized in the last 3 years? Yes No
If yes, what for? _____

Are you in poor health?	Yes	No	Have there been any changes in your health this year?	Yes	No
Have you ever been seriously ill?	Yes	No	Have you ever been treated for a growth or tumor?	Yes	No
Do you bruise easily?	Yes	No	Have you ever had painful or swollen joints?	Yes	No
Do you have chest pain on exertion?	Yes	No	Do you often feel exhausted or fatigued?	Yes	No
			Do you bleed a long time when you are cut?	Yes	No
Do you have a pacemaker?	Yes	No	Are you prone to motion sickness?	Yes	No
(WOMEN) Are you pregnant?	Yes	No	If NO, are you currently taking birth control pills?	Yes	No

(CHILD) Are immunizations current for diphtheria, pertussis, tetanus, measles, mumps & polio? Yes No
Do you use Tobacco (smoking or chewing)? Yes No If yes, How often? _____/day

Dental History

Have you been having any specific problem?	Yes	No	If Yes, explain _____		
Has fear of discomfort kept you from regular visits?	Yes	No	Do your gums bleed?	Yes	No
Have you noticed any loosening of your teeth?	Yes	No	Do you or have you had sinus trouble?	Yes	No
Do you have difficulty chewing your food?	Yes	No	Are you troubled with bad breath?	Yes	No
Do your jaws “pop/lock” when opening your mouth?	Yes	No	Do you have sensitive teeth?	Yes	No

Have you ever had any severe reaction to dental treatment or local anesthetics? Yes No
If yes, explain_____

Do you require antibiotic pre-medications for a heart condition, artificial valve or artificial joints? Yes No
Have you ever taken Fosamax, Boniva, Aredia, or any drugs prescribed to decrease bone resorption? Yes No
Are you currently taking any medication or recreational drugs? Yes No
Please list here and what they are for: _____
_____
_____
_____

Preferred Pharmacy: _____

Allergies

Are you allergic, or had any negative reactions to any of the following (circle all that apply)?

Penicillin Tetracycline Sulfa Drugs Aspirin Codeine Latex Other_____ **NONE**

Have you ever had any of the following? **Please circle all that apply**:

Loss of Weight	Aspirin Therapy	Glaucoma	Fainting Spells
Dysentery	Ulcer	Diabetes	Alcoholism
Open Sores	Night Sweats	Rheumatic Fever	Hepatitis
Loss of Appetite	Toxoplasmosis	Radiation Therapy	Jaundice
Organ Transplant	Osteoporosis	Tuberculosis	Epilepsy
Psychiatric Treatment	Chills	Low Blood Pressure	MAO Inhibitors
Swollen Glands	Persistent Cough	High Blood Pressure	Prosthetic Joint
Swelling of ankles	Tricyclic Antidepressants	Mitral Valve Prolapse	Anorexia
Spontaneous Bleeding	Emphysema	Venereal Disease	Bulimia
Herpes	Stroke	Drug Addiction	Bloody Sputum
Blood Thinners	Fever (unknown origin)	Heart Murmur	Hemoptysis
Aids Test	Arthritis	Frequent Headaches	**NONE**