PATIENT INFORMATION

Today's Date _____/_____/_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid / Partner

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	SSAN/HIC/Patient ID#	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer/School	Employer/School Phone No. ( )

Chose Us Because/Referred to us by (Please check one box) ❑ Dr. ____________________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ____________________

Other Family Members Seen Here

PRIMARY INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD[S] TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
Is this person a patient here?	❑ Yes ❑ No		( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

SECONDARY INFORMATION (if required)

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

DENTAL HISTORY

Please check "Yes" or "No" to indicate if you have or have had any of the following:

Condition	Yes	No	Condition	Yes	No
Bad breath ☐	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	EI No
Foreign objects in mouth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in mouth	☐ Yes	☐ No

Former Dentist ____________________ City/State ____________________

Date of last dental visit ____________________ Date of last dental X-rays ____________________

How often do you floss? ____________________ How often do you brush? ____________________

Do you wear contact lenses? ❑ Yes ❑ No

MEDICAL HISTORY

Please check “Yes” or “No” to indicate if you have or have had any of the following:

AIDS	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Back Problems Cancer	☐ Yes ☐ Yes	☐ No ☐ No	Low Blood Pressure Nervous Problems	☐ Yes ☐ Yes	☐ No ☐ No
Chemical Dependency	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Shortness of Breath	☐ Yes	El No
Cough, persistent or bloody	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Special Diet/Weight Loss	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Hepatitis Type ________	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Hernia Repair	☐ Yes	☐ No	Ulcer	☐ Yes	El No
High Blood Pressure	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
HIV Positive	☐ Yes	☐ No			
Have you ever had any complications following dental treatment?	☐ Yes	☐ No	**Have you ever had or been diagnosed with:**		
If yes, please describe:			Artificial Heart Valves	☐ Yes	☐ No
			Artificial Joints, Screws, Pins, etc.	☐ Yes	☐ No
			Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Women: Are you Pregnant?	☐ Yes	☐ No	Blood Disease	☐ Yes	El No
Due Date:			Congenital Heart Lesions	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Taking birth control pills?	☐ Yes	☐ No	Hernia Repair	☐ Yes	☐ No
			Mitral Valve Prolapse	☐ Yes	☐ No
			Pacemaker	☐ Yes	☐ No
			Rheumatic Fever	☐ Yes	☐ No
Have you ever been hospitalized or do you have other health concerns? If so, please describe:	☐ Yes	☐ No	**Medications: Have you ever taken or are you allergic to any of the following:**		
			Aspirin		
			Barbiturates		
			Codeine		
			Ibuprofen		
			Latex		
			Local Anesthesia		
Please PRINT all medications now taking:			Metals (i.e. Gold)		
			Penicillin		
			Other drug allergies:		
			Blood Thinners (Coumadin or Warfarin)		
			Diet Medications (Dexfenfluramine, Fen-phen, Pondimin, Redux)		
			Levoxyl		
			Synthroid		

Former Dentist ____________________________ City/State ________________________ Date of last dental visit _______________________

Date of last dental X-rays _____________ How often do you floss? ______________ How often do you brush? __________________

Do you wear contact lenses? ❑ Yes ❑ No

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. Insurance Assignment: I certify that I, and/or my dependent(s). have insurance coverage with ____ and assign directly to Dr. ____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize Dr. Brian Kerr DMD PS to use and/or disclose my Protected Health Information (PHI) related to my treatment. The information will be used and/or disclosed for the purpose of:____. I authorize Dr. Brian Kerr DMD PS to receive and use the information.

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be redisclosed by the recipient and may no longer be protected by federai privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

X ____

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

____

PLEASE PRINT NAME OF PATIENT. PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT