Kimball & Beecher
FAMILY DENTISTRY

* REQUIRED INFORMATION

Patient Personal Information

Title _____ Nickname _____ *Birth Date _____ Age _____
Last, First * _____ _____ _____ Marital Status _____ Gender ☐M / F☐
Address * _____ *Home # _____ Work # _____
_____ Cell # _____ Drive Lic # _____
City, State, Zip* _____ Student ☐FT / PT☐ *SSN _____
Email _____ School Name _____

Insurance / Policy Holder Information

Insurance Co. * _____ *Policy # _____ *Group # _____
Subscriber's Subs. Birth Date _____ _____
Last, First * _____ _____ _____ Marital Status _____ Gender ☐M / F☐
Address * _____ Home # _____ Work # _____
_____ Cell # _____ Drive Lic _____
City, State, Zip* _____ Subs. SSN _____
Employer * _____ Patient relationship to subscriber _____

Referral Source

How did you hear about our office? _____

☐ Family / Friend: Name _____
☐ Internet/Website/Google ☐ Employee Referral Name _____
☐ Television ☐ Mailer Coupon ☐ Radio ☐ Newspaper
☐ Walk in-sign ☐ Insurance Plan Other _____
☐ Dex/Yellowbook

Patient Medical Information — **Please check yes or no**

Allergic To

☐Y ☐N No Known Allergies
☐Y ☐N Amoxicillin
☐Y ☐N Aspirin
☐Y ☐N Barbiturates / Sleeping Pills
☐Y ☐N Codeine
☐Y ☐N Epinephrine
☐Y ☐N Erythromycin
☐Y ☐N Iodine
☐Y ☐N Latex/Rubber
☐Y ☐N Local Anesthetics
☐Y ☐N Metals
☐Y ☐N Penicillin
☐Y ☐N Sulfa Drugs
☐Y ☐N Other Not Listed Above:

Check, if within last 10 years

☐Y ☐N No Known Concerns or Issues
☐Y ☐N AIDS/HIV Infection
☐Y ☐N Alcohol/Drug Abuse
☐Y ☐N Anemia
☐Y ☐N Ankles Swell
☐Y ☐N Anorexia
☐Y ☐N Arthritis
☐Y ☐N Asthma / Hay Fever
☐Y ☐N Blood Clotting Problems
☐Y ☐N BLOOD THINNERS
☐Y ☐N Blood Transfusion
☐Y ☐N Bronchitis
☐Y ☐N Bulimia
☐Y ☐N Cancer / Tumor or Growth
☐Y ☐N Cardiac Pacemaker
☐Y ☐N Chemotherapy
☐Y ☐N Chest Pain Upon Exertion
☐Y ☐N Color Blindness
☐Y ☐N Contact Lenses
☐Y ☐N Damaged Heart Valve
☐Y ☐N Deaf
☐Y ☐N Depression / Anxiety
☐Y ☐N Diabetes
☐Y ☐N Emphysema
☐Y ☐N Epilepsy
☐Y ☐N Fainting Spells / Seizures
☐Y ☐N Fever Blisters / Cold Sores
☐Y ☐N Frequent Headaches
☐Y ☐N Frequently Dry Mouth / Sjogren
☐Y ☐N Gall Bladder Trouble
☐Y ☐N Heart Attack / Stroke
☐Y ☐N Heart Disease / Angina
☐Y ☐N Heart Murmur
☐Y ☐N Hepatitis
☐Y ☐N High Blood Pressure
☐Y ☐N Hives / Skin Rash
☐Y ☐N Jaundice
☐Y ☐N Joint Replacement
☐Y ☐N Kidney / Bladder Trouble
☐Y ☐N Liver Disease
☐Y ☐N Low Blood Pressure
☐Y ☐N Mental Health Problems
☐Y ☐N Mitral Valve Prolapse
☐Y ☐N Persistent Diarrhea
☐Y ☐N Premedication Required
☐Y ☐N Rheumatic Fever
☐Y ☐N Rheumatic Heart Disease
☐Y ☐N Seasonal Allergies
☐Y ☐N Sexually Transmitted Disease
☐Y ☐N Shortness of Breath
☐Y ☐N Sinus Trouble
☐Y ☐N Stomach Ulcers
☐Y ☐N Thyroid Problems
☐Y ☐N Tuberculosis
☐Y ☐N Unusual Weight Loss
☐Y ☐N Urinate Frequently

OTHER

☐Y ☐N List of CURRENT Medications

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist	_____	
Date of your last cleaning, exam, x-rays	_____	
Do your gums bleed while brushing or flossing?	☐ Y	☐ N
Are your teeth sensitive to hot, cold or sweets?	☐ Y	☐ N
Do you chew/smoke tobacco in any form? How much per week?	_____	
Have you had any head, neck or jaw injuries?	☐ Y	☐ N
Do you notice popping, clicking or soreness of the jaws?	☐ Y	☐ N
Do you clench or grind your teeth?	☐ Y	☐ N
What Specific Problems are you having with your teeth, gums, or mouth at this time?	_____	
Do you have difficulty in opening your mouth widely?	☐ Y	☐ N
Do you have an unpleasant taste or odor in your teeth/mouth?	☐ Y	☐ N

Medical Questionnaire

Medical Questionnaire

Family Physician name and phone #	_____	
Are you currently taking any medication?	☐ Y	☐ N
List of current medications	_____	
	_____	
Are you currently under care of a Physician?	☐ Y	☐ N
If Yes, what is the condition being treated?	_____	
List Any serious illness, operation or hospitalization within the past 5 years?	_____	
Have you taken Osteoporosis meds? (Fosamax, Boniva, Zometa, Actonel)	☐ Y	☐ N
Have you ever taken the diet control drug Fen-Phen?	☐ Y	☐ N
Do you use alcoholic beverages?	☐ Y	☐ N
Have you been diagnosed with bleeding disorder?	☐ Y	☐ N
Any Disease, Condition or Problem not Listed? Please list	_____	
Women Only		
Are you pregnant? What is your due date?	_____	
Are you currently nursing?	☐ Y	☐ N
Are you on hormone replacement therapy or fertility drugs?	☐ Y	☐ N
Are you on birth control?	☐ Y	☐ N

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ **Patient/Guardian Signature**

_____ **Date**