Wakarusa Family Dental

Allen K. Kelley DDS

Patient Information

Last Name: _____**First Name**: _____ **MI:** ____ **Preferred Name:** _____

SS#: _____-_____-_____**DOB:** _____/_____/_____ **Age:** _____ **Sex: F M Single Married Divorced Minor**

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Cell#: _____-_____-_____**Home #:** _____-_____-_____ **Work #:**_____-_____-_____

E-mail: _____**Patient Employer:** _____

Spouse: _____**Emergency Contact:** _____**Ph#:**_____-_____-_____

- **I prefer to have appointments confirmed via: ____ Text ____ Email ____ Phone Call**

Responsible Party (*Person listed will be <u>fully</u> responsible for this account, which includes any/all financial obligations)*

Last Name: _____**First Name:** _____ **MI:** _____

DOB: _____/_____/_____ **SS#:** _____-_____-_____ **Relationship to Patient:** _____

Address: _____**City:**_____**State:**_____ **Zip:** _____

Cell/Contact#: _____-_____-_____ **Employer:** _____ **Work#:** _____-_____-_____

Dental Insurance (*<u>Please</u>* provide ***<u>only</u>*** dental insurance information, and ***<u>not</u>*** medical insurance information)

Primary <u>Dental</u> Insurance: _____**Subscriber:** _____**DOB:** _____/_____/_____

Relationship to Patient: _____ **SS#:**_____-_____-_____ **Policy ID#:** _____

Subscriber's Employer: _____

Secondary <u>Dental</u> Insurance: _____ **Subscriber:** _____**DOB:** ____/_____/_____

Relationship to Patient: _____ **SS#:** _____-_____-_____ **Policy ID#:** _____

Subscriber's Employer: _____

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We have the right to change our privacy practices as described in our Notice of Privacy Practices, which you have the right to read before signing this form. I had the full opportunity to read and consider the contents of this Consent Form and Notice of Privacy Practices.

- **I give permission to release information about my dental treatment and records to the following person(s):**

  _____ _____ _____

Patient/Legal Guardian Signature: _____ **Date:** _____

PLEASE COMPLETE REVERSE SIDE

Please Fill Out Information Below: **Patient Name:**_____

DENTAL HISTORY

Do your gums bleed……...…Y N

Last dental cleaning?_____

Do you grind or clench your teeth……Y N

Teeth sensitive to Hot__ Cold___ Sweet___

Have you noticed your bite changing….Y N

Do you fear dental treatment? ……..Y N

Have you been treated for periodontal disease……Y N

Are you satisfied with the appearance of your teeth?..... Y N

Do you use tobacco products?.....Y N

Have you had treatment to straighten your teeth?..... Y N

Have you been told by a Surgeon/Physician to take antibiotics prior to dental treatment?.... Y N

MEDICAL HISTORY

Please check all that currently apply

____Anemia
____Artificial Joints
____Artificial Heart Valve
____Asthma
____Blood Disease
____Blood Thinner
____Cancer
____Chemical Dependency
____Chemo-therapy
____Diabetes
____Epilepsy
____Head Injuries
____Heart Attack
____Heart Disease
____Heart Murmur
____Hepatitis (A, B, C, other)
____High Blood Pressure
____HIV
____Pacemaker
____Pregnancy
____Radiation Treatment
____Respiratory Problems
____Rheumatic Fever
____Sinus Problems
____Stroke
____Swollen Neck Glands
____Tuberculosis

Medical Allergies? Y N
(please check all that apply)
____Amoxicillin/Penicillin
____Aspirin
____Codeine
____E-mycin
____Keflex
____Latex
____Local Anesthesia
____Sulfa
____Other:_____
_____

Have you had any serious illness, operations or hospitalizations? Y N (please list below):

_____

MEDICATIONS AND DOSAGE

Please write below or attach a list of current medications and dosage

_____
_____
_____
_____
_____