



KEVIN C. DICKINSON ^{DC} DENTISTRY

DATE: _____

MEDICAL AND DENTAL HISTORY

In order to safeguard your health, it is important that you answer the following questions. Please remember that the answers to these questions are held in strict confidence.

Patient's Name _____ Email _____

Birthdate _____ Home Tel. _____ Cell _____ Bus. Tel. _____

Address _____ Who referred you to our office _____

City _____ State _____ Zipcode _____ Physician _____

Employer _____ Occupation _____ SS# _____

Parent or Guardian _____ Bus. Tel. _____

Whom may we contact in case of an emergency _____ Contact Tel. _____

1. Are you under any medical treatment now? If so, what? _____
2. Have you had any major operations? If so what? _____
3. Are you now taking any drugs, medicine, or pills? _____
If yes, Please list or attach _____
4. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? _____
5. Are you employed anywhere that exposes you to x-rays or ionizing radiation? _____
6. Indicate which of the following you have had or have at present. Circle each item.

Artificial Heart Valve	Tuberculosis (TB)	Emphysema	Liver Disease
Artificial Joints (Hip, Knee)	Heart Surgery	Asthma	Drug Addiction
Cortisone Medicine	Heart Disease or Attack	Sinus Trouble	Cold Sores / Fever Blisters
Diabetes	Congenital Heart Lesions	Allergies	Epilepsy or Seizures
Hemophilia	Heart Pacemaker	Thyroid Disease	Fainting or Dizzy Spells
Hepatitis A, B, or C	Anemia	Arthritis	Psychiatric Treatment
Radiation or Chemotherapy	Stroke	Rheumatism	Sickle Cell Disease
High Blood Pressure	Kidney Trouble	Glaucoma	Tested for H.I.V.
Mitral Valve Prolapse	Ulcers	Pain in Jaw Joints	Tested Positive for H.I.V.

7. Do you have difficulty breathing when lying down? YES NO

8. Are you allergic to, or have you ever acted adversely to: (circle any that apply)

- | | |
|--------------------------------------|--------------|
| Local anesthetic (such as novocaine) | Aspirin |
| Penicillin | Codeine |
| Erythromycin | Other? _____ |

9. Is there any condition you feel your dentist should know about before undertaking dental treatment?

If So, explain _____

FOR WOMEN ONLY:

Are you pregnant? YES NO. If yes, what month?

Are you taking birth control pills? YES NO

PATIENT DENTAL HISTORY

1. What is the reason for this initial visit? _____
2. Do you have any other dental problems at this time? _____
3. When was your last visit to a dentist? _____
4. When were your last full mouth x-rays taken? _____
5. Does it ever hurt to open wide, take a big bite, or have any difficulty in opening the mouth wide? _____
6. Does your jaw ever make noise (popping, cracking, grating, etc.) or does your jaw ever lock? _____
7. Do your gums bleed easily? _____
8. Are your gums red, swollen or tender? _____
9. Does food wedge between your teeth? _____
10. Are any of your teeth separating or loose? _____
11. Do you have any missing teeth? _____
12. Are you happy with your smile and the appearance of your teeth in general? (Color, Space, Shape, Chewing) Explain _____

PAYMENT POLICY

In compliance with the Truth in Lending Law here is our credit policy: It is customary to take care of fee at time service is rendered unless other arrangements have been made. To assist you with this we accept major credit cards. Any balance not paid in full is subject to 1.5% interest per month.

INSURANCE

To avoid misunderstanding regarding dental insurance, we wish our patients to know that all services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will be happy to assist in the preparation of necessary insurance forms.

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____
Insurance Co. Address _____
Insurance Co. Phone # _____
Group # (Plan, Local or Policy#): _____
Insured's Name: _____ Relation: _____
Insured's Birthday: _____ Insured's SS#: _____
Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____
Insurance Co. Address _____
Insurance Co. Phone # _____
Group # (Plan, Local or Policy#): _____
Insured's Name: _____ Relation: _____
Insured's Birthday: _____ Insured's SS#: _____
Insured's Employer: _____

PERMIT FOR TREATMENT: This is to certify that I, undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable including the use of local anesthetic and x-rays as indicated and will assume responsibility for fees associated with those procedures.

PATIENT'S SIGNATURE _____ DATE _____

PARENT'S SIGNATURE (for minor patient) _____ DATE _____