Patient Information

Date: _____

Patient Name: _____ Sex: ☐ F ☐ M Age: _____

Birthdate: _____ ☐ Single ☐ Married ☐ Minor ☐ Widowed ☐ Divorced ☐ Partnered

Social Security #: _____ Email: _____

Address: _____ City: _____ Zip: _____

Home #: _____ Cell #: _____ Work#: _____

Patient Employer or School: _____ Occupation: _____

Whom may we thank for referring you to our office? _____

Insurance

Who is responsible for this account? _____ Phone: _____

Subscriber Name: _____ Birthdate: _____

SS# or ID#: _____ Relationship to Patient: _____

Employer: _____ Insurance Name: _____ Group #: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name: _____ Birth date: _____

SS# or ID#: _____ Relationship to Patient: _____

Employer: _____ Insurance Name: _____ Group #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above insurance(s) and assign directly to **Angela Klingensmith, D.D.S.** 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 dentist 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.

_____ _____

X Patient Signature, Parent, or Guardian **Date**

Dental Information

Reason for today's visit _____ Date of last dental visit _____

Former Dentist Name & Address _____

Have you had any of the following?

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

How often do you floss? _____

How often do you brush? _____

Health Information

Physician Name: _____ Date of last visit: _____

Have you ever used a bisphosphonate medication? ☐ Yes ☐ No Common brand names are: Fosamax, Actonel, Atelvia, Didronel, and Boniva

Please list all medications you are currently taking: _____

Allergies: ☐ Latex ☐ Penicillin ☐ Sulfa ☐ Other _____

Circle Any of the Following Conditions That You Have Had or Now Have

AIDS/HIV	Chemical Dependency	Hepatitis Type_____	Tumor/growth on head or neck
Arthritis	Diabetes	Herpes	Bleeding abnormally, with extractions or surgery
Artificial Heart Valves	Epilepsy	High Blood Pressure	
Artificial Joints	Fainting or Dizziness	Stroke	Other Diseases _____
Cancer	Heart Problem	Tuberculosis	

Women: Are you pregnant? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

X Patient Signature, Parent, or Guardian **Date**

_____ _____

X Reviewed by **Date**