welcome

Date: _____ New Patient Former Patient Emergency

Name: _____ Adult Child

Preferred Name: _____

Address: _____

_____

Cell #: _____ Home #: _____

E-mail Address: _____

Contact Method: E-mail Phone Text

Referred by: _____

Patient's Concerns or Needs: _____

_____

Last Visit to the Dentist: _____ Last Cleaning: _____ Last X-Rays: _____

Request of Records from Dr. _____

Have you ever been treated for periodontal disease? Yes No If yes, date: _____

Any medical condition that we need to be aware of or would require the patient to premedicate:

_____

Do you have insurance? Yes No If yes, company: _____

patient registration

About You

Date

Last Name | First | M.I.

Preferred Name

Address

City | State | Zip

Home # | Fax #

Cell # | E-mail

Social Security #

Birthdate | Age | Married | Single

Male | Female | Divorced | Widowed

If this appointment is for your child, please fill below

School | Grade

Account Information

Person Financially Responsible for Account

Occupation

Relation

Address

City | State | Zip

Phone # | E-mail

You

Occupation | Employer

Employer Address

Employer's Phone # | Employer's Fax #

Your Spouse

Occupation | Employer

Employer's Address

Employer's Phone # | Employer's Fax #

Dental Insurance

Do you have insurance?

If you have insurance, please fill below

Insurance Company

Insurance Co. Address

Insurance Co. Phone #

Group #

Insured's Name | Relation

Insured's Birthdate | Insured's Employer

Insured's ID #

Insured's Social Security #

Getting to Know You

Is another relative our patient?

Name | Relationship

You were referred to us by

Emergency Contact

Name | Phone #

Address

City | State | Zip

Closest Relative Not Living with You

Name | Phone #

Address

Employer's Address

Employer's Phone # | Employer's Fax #

continued on next page

dental history

What is the reason for your visit today? _____

Date of Last Dental Visit: _____ Last Dental Cleaning: _____ Last Fully Mouth X-rays: _____
What was done at your last dental visit? _____

_____

Previous Dentist's Name: _____
Address: _____
Telephone:_____ E-mail: _____
How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
Have you ever used or are currently using topical fluoride? Yes No
What other dental aids do you use? (Interplak, toothpick, etc.) _____
Do you have any dental problems now? Yes No
If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Have you noticed any moth odors or bad taste?	Yes	No
Do you frequently get cold sores, blisters, or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite place or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause: _____
_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches, or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern? _____
_____ Yes No

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe: _____
_____

Have you ever been told to take a pre-medication prior to dental treatment?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe: _____
_____
_____

continued on next page

medical history

1. Physician's Name: _____ Phone: _____
   Have you had any medical care within the past two years? Yes No
   Describe: _____
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you currently taking any medication, drugs, pills, or herbal remedies, including regular doses of asprin? Yes No
   If yes, please list name and dosage:
4. Have you ever taken prescription medications for weight loss (diet pills)? Yes No
   If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues? Yes No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other similar drugs? Yes No
6. Have you been a patient in the hospital during the past five years? Yes No
7. Indicate which of the following you have had, or have at present. Circle yes or no to each item.

Heart (Surgery, Disease, Attack)	Yes No	Ulcers	Yes No	Hepatitis A B C (circle)				
Chest Pain	Yes No	Diabetes	Yes No	Venereal Disease	Yes No			
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	A.I.D.S./H.I.V. Positive	Yes No			
Heart Murmur	Yes No	Glaucoma	Yes No	Cold Sores/Fever Blisters	Yes No			
High/Low Blood Pressure	Yes No	Contact Lenses	Yes No	Blood Transfusion	Yes No			
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Hemophilia	Yes No			
Artificial Heart Valve/Pacemaker	Yes No	Chronic Cough	Yes No	Sickle Cell Disease	Yes No			
Rheumatic Fever	Yes No	Tuberculosis	Yes No	Bruise Easily	Yes No			
Arthritis/Rheumatism	Yes No	Asthma	Yes No	Liver Disease/Yellow Jaundice	Yes No			
Cortisone Medicine	Yes No	Hay Fever/Allergy/Hives	Yes No	Neurological Disorders	Yes No			
Swollen Ankles	Yes No	Latex Sensitivity	Yes No	Epilepsy or Seizures	Yes No			
Stroke	Yes No	Sinus Trouble	Yes No	Fainting or Dizzy Spells	Yes No			
Diet (Special/Restricted)	Yes No	Radiation Therapy	Yes No	Nervous/Anxious	Yes No			
Artificial Joints (hip, knee, etc.)	Yes No	Chemotherapy	Yes No	Psychiatric/Psychological Care	Yes No			
Kidney Trouble	Yes No	Tumors	Yes No					

8. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No
9. Have you lost or gained more than 10 pounds in the past year? Yes No
10. Do you have or have you had any disease, condition, or problem not listed? Yes No
11. Women: Are you pregnant or think you could be pregnant? Yes _____ months No Nursing? Yes No
12. Do you use birth control prescriptions? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care p rovider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: _____ Date: _____

History Review

Dentist Signature: _____ Date: _____

consent for treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature: _____ Date: _____ Witness: _____

Parent/Responsible Party's Signature: _____ Relation to Patient: _____

acknowledgement of receipt of notice of privacy practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

broken appointment policy

At Kenilworth Dental Associates, we realize that your time is valuable, and we appreciate your mutual understanding that our time is valuable too. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 48 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below so that you do not encounter any unexpected fees:

- Any patient who does not show or cancels/reschedules an appointment and has not contacted our office with at least 48 hours notice will be considered a No Show and charged $100.00 per hour reserved for the appointment.
- Any patient who does not show or cancels/reschedules without 48 hours notice 3 times may be dismissed from the practice.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our front desk. You may contact our office (847)256-7700. Should it be after our regular business hours, you may leave a message.

I have read and understand the Dental Appointment Cancellation/No Show Policy.

Patient's Signature: _____ Date: _____

Parent/Responsible Party's Signature: _____ Relation to Patient: _____