Welcome!

SOUTH KIPLING DENTAL CARE

DR. JOHN OFFERDAHL • DR. DAN LARSEN

The Patient

Thank you for taking the time to completely fill out this questionnaire.

Today's date ______

Name ______ Preferred Name ______

Birth Date ______ Age ______ SS# ______

Home Address ______ City ______ Zip ______

Home Phone ______ Work Phone ______ Driver's License# ______

Cell Phone ______ Email ______

Employer ______ Address ______

How Long Employed ______ Occupation ______

Spouse's Name ______ Spouse's Work Number ______

Parent or Guardian if under 18 years of age ______

Whom to notify in case of emergency ______ Relationship ______

Address ______ Phone ______

Who referred you to our office? ______

Medical History

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is protected under HIPPA regulations

Do you use ❑ cigars/cigarettes, ❑ pipe or ❑ chewing tobacco?

Are you currently under a physicians care?
❑ Yes ❑ No If Yes, why? ______

Are you pregnant? ❑ Yes ❑ No
If yes, when are you due? ______

What medications are you currently taking?
______

Family Physician ______
Phone Number ______

Office Use Only:
______

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or attack	AIDS/ARC/HIV Pos.	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Hepatitis C	Asthma
Rheumatic Fever	Liver Disease	Hay fever
Congenital Heart Lesions	Blood Transfusion	Sinus Trouble
Mitral Valve Prolapse	Drug Addiction	Allergies or Hives
Artificial Heart Valve	Hemophilia (Bleeding Problems)	Diabetes
Heart Pacemaker	Fever Blister	Thyroid Disease
Heart Surgery	Epilepsy or Seizures	Radiation Treatment
Artificial Joints (Hip, Knee)	Nervousness	Arthritis
Anemia	Psychiatric Treatment	Cortisone Medicine
Stroke	Glaucoma	Pain in Jaw Joints
Kidney Trouble	Chemotherapy (Cancer, Leukemia)	Alcoholism
Ulcers	Venereal Disease (Syphilis, Gonorrhea, etc.)	Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin	Latex (balloons, gloves, etc.)
Nitrous Oxide	Codeine	Penicillin	

Are you aware of being allergic to any other medications or substances? ______
If yes, please list: ______
Is there any other Medical or Dental information that you feel I should know about?
______

CONTINUED ON REVERSE

Dental History

Why have you come to see the dentist today? ______________________________

____

Are any of your teeth sensitive to:

Heat	❑ Yes	❑ No	Cold	❑ Yes	❑ No
Biting Pressure	❑ Yes	❑ No	Sweets	❑ Yes	❑ No

Are you currently experiencing any dental pain?	❑ Yes	❑ No
Does food catch in your teeth?	❑ Yes	❑ No
Have you ever had any teeth extracted?	❑ Yes	❑ No
Do your gums bleed when brushing or flossing?	❑ Yes	❑ No
Do you like the appearance of your teeth?	❑ Yes	❑ No
Would you like to have whiter teeth?	❑ Yes	❑ No
Do you feel you may someday wear dentures?	❑ Yes	❑ No
Does your jaw joint bother you?	❑ Yes	❑ No

When did you last see a dentist? ____________ Why did you leave your last dentist? ____________________

Please rank the following in order in which they would keep you from having dental treatment: 1 = Most important

Fear of Pain _____ Lack of Concern _____ Cost of Treatment _____ Missing work time _____

Insurance

PRIMARY DENTAL INSURANCE

Insured's Name ______________________ Birth Date ____________ SS# ____________

Employer ______________________ Group Plan Policy Number ____________________

Insurance Company ______________________ Phone ____________________

Insurance Company Address ______________________________

____

THE INFORMATION I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I MUST INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all form of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) ______________________ Date ____________ Witness ____________________