KAUFMAN DENTISTRY
GENERAL FAMILY & COSMETIC DENTISTRY

Patient Information

First Name_____ **Last Name** _____ **Middle Initial**_____

Date of Birth_____

E-Mail _____

SS# _____-_____-_____

Home Address_____

City/State/Zip_____

Cell Phone # (_____) _____

Home Phone# (_____) _____

Occupation_____

Employer_____

Work Address _____

City/State/Zip _____

Work Phone (_____) _____

Office Use Only:

Medical Alerts: _____

_____

_____

Other Notes: _____

_____

_____

Primary Dental Insurance (if applicable)_____**Group #**_____ **ID #**_____

Name of Insured_____ **Relationship to insured** _____

Employer of Insured _____ **DOB of Insured** _____

Secondary Dental Insurance (if applicable) _____**Group #**_____**ID#**_____

Name of Insured_____ **Relationship to insured** _____

Employer of Insured _____ **DOB of Insured** _____

Medical Insurance (if applicable)_____ **Group #**_____**ID #**_____

Primary Physician's Name:_____ **Phone #**_____

Emergency Contact Name: _____**Phone #**_____

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

Signature_____ **Date** _____

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Medical Questions - Please check each question individually

Yes	No	Do you have or have you ever had….
		Asthma?
		Allergies to food or medications? Please specify:
		Sensitivity to Latex?
		Reaction to local or general anesthetics?
		Blood pressure problems?
		Heart attack, prosthetic heart valve, heart murmur, or other heart condition?
		Stroke, Cerebrovascular accident (CVA), or Transient Ischemia Attack (TIA)?
		Rheumatic Fever or Infective Endocarditis?
		A Pacemaker?
		Artificial Joints? Please specify:
		Diabetes?
		Liver, Kidney, or thyroid problem?
		Hepatitis?
		Tuberculosis or lung problems?
		Bleeding or Clotting Disorder? Please specify:
		Arthritis?
		Sexually transmitted disease? Please specify:
		Cancer? Please specify:
		Depressions or Anxiety?
		Other illness not listed? Please specify:
		Have you ever been hospitalized? Please specify:
		In the past two years have you taken prescription steroids (ie prednisone, medrol dose pack, etc)
		Have you ever used bisphosphonate medication? ie: Fosamax
		Do any wounds heal slowly or present complications?
		Do you use any recreational drugs including medical marijuana? Please specify:
		WOMEN: are you currently on birth control or pregnant? Please circle.

Please list all medications and dosages that you are currently taking:

MEDICATION NAME	DOSAGE

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Dental Questions - Please check each question individually

Yes	No	
		Do you use any tobacco products? If so what and how much?
		Do you have pain in your jaw or near your ears?
		Do you have frequent headaches?
		Do you have frequent neck/shoulder pain?
		Do you clench or grind your teeth at night or during the day?
		Do you have any injuries or inflamed areas in your mouth?
		Do your gums bleed when you brush or floss?
		Do you have a bad taste in your mouth?
		Do you have bad breath?
		Do you chew on only one side of your mouth?
		Is any part of your mouth sensitive to hot, cold, pressure, or sweets?
		Have you had problems with previous dental care?
		Are you anxious about receiving dental care?
		Are you happy with the color of your teeth?
		Are you happy with the position of your teeth?
		Is there anything else you would like to change about the appearance of your teeth?
		Do you sleep well?
		Do you snore or have you been told that you snore?
		Have you been told that you sometimes stop breathing in your sleep?
		Are you tired during the day?
		Do you wake up multiple times at night to use the bathroom?
		Do you take medication to help you sleep? If so what?
		Do you get heartburn? If so when and how often?

When and where was your last dental exam?_____

Primary dental concern_____

I certify that the above statements are accurate and complete. I hereby authorize and give consent to Kaufman Dentistry, Inc. to perform all services and dental treatment, including necessary radiographs, for scheduled, walk-in, and emergency appointments. I further understand that all dental records including x-rays are and will remain the property of this dental office. I have received copies of the fact sheet on dental materials and HIPAA policies.

Patient's Signature _____**Date**_____

Reviewed By_____Date_____

Updates (to be filled out by Kaufman Dentistry)

Date_____ Change _____Initials_____

Date_____ Change _____Initials_____

Date_____ Change _____Initials_____