Patient Information

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Name _____ Date of Birth _____/_____/_____ Male ☐ Female ☐
First Last Mi

Address _____ City _____ State ____ Zip _____

Social Security Number _____ Single ◯ Married ◯ Child/Minor ◯
Necessary for insurance purposes

Cell _____ Home _____ Work _____

Email _____ Emergency Contact _____
Used to confirm appointments & notify you when it is time to schedule # _____

Employer _____ Occupation_____

How did you hear about our office? ☐ Insurance Site ☐ Google/Website ☐ Sign/Location ☐ Flyer in Mail
☐ Other ☐ Family/Friend (Name) _____

Insurance Information

Insurance Co. Name _____ Member ID _____

Insurance Co. #_____ Group # _____
Provider/Benefits (usually on back of card)

Policy Holder/Subscriber Information (If patient does NOT carry the insurance plan provided to them)

Name _____ DOB _____ Social Security # _____

Address _____
Street City State Zip

Financial Responsibility (If patient is a child/minor) _____ _____
Full Name Phone

Address of Responsible Party _____

Financial Agreement

Welcome to our office. We will do our best to make your experience with us a pleasant one. We will provide you with an **estimate** of your coverage with the information we obtain from your insurance company. We require any co-pays and/or deductibles to be paid at the time of service. As a courtesy, we will file a claim with your dental insurance company on your behalf. If your insurance has not paid your account in full within 60 days, the balance will be automatically transferred to you for payment. I further agree that if the account is turned over to a collection agency or attorney, I will be responsible for all collection costs, interest allowed at the current legal rate, and/or any reasonable attorney fees occurred. Thank you for understanding our financial policy.

Patient Signature _____ Date _____
Parent or Legal Guardian if Minor

Keystone DentalGroup

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____

_____

_____

_____

_____

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Hospitalizations & Surgeries

Reason	Date

Dental History

When was your last dental exam?

Date _____

When were your last dental x-rays taken?

Date _____

How often do you brush? # times/day _____

How often do you floss? # times/day _____

Do you grind your teeth?

☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment?

☐ Yes ☐ No

Have you ever had periodontal (gum) treatments?

☐ Yes ☐ No

Do you have any of the following?

☐ Bad Breath ☐ Dry Mouth ☐ Partials
☐ Bleeding Gums ☐ Difficulty Chewing ☐ Sensitivity to Cold
☐ Blisters on Mouth ☐ Ear Pain ☐ Sensitivity to Heat
☐ Broken Fillings ☐ Jaw Pain ☐ Sensitivity to Sweets
☐ Clicking Jaw ☐ Loose Teeth ☐ Sensitivity to Pressure
☐ Dentures ☐ Mouth Pain ☐ Swollen Gums
☐ Difficulty Opening or Closing ☐ Mouth Sores

Past Medical History

Have you ever had any of the following?

☐ Alcoholism ☐ Bleeding Disorder ☐ Eating Disorder
☐ Allergies ☐ Blood Disease ☐ Epilepsy
☐ Anemia ☐ Blood Transfusion ☐ Hay Fever
☐ Anxiety Disorder ☐ Bowel Disorder ☐ Heart Disease
☐ Arthritis ☐ Cancer ☐ Heart Problems
☐ Asthma ☐ Diabetes ☐ Hepatitis - A, B, or C
☐ AIDS / HIV ☐ Depression ☐ High Blood Pressure
☐ High Cholesterol ☐ Migraines ☐ Stomach Ulcer
☐ Joint Disorder ☐ Osteoporosis ☐ Substance Abuse
☐ Kidney Disorder ☐ Pacemaker ☐ Thyroid Disorder
☐ Liver Disorder ☐ Rheumatic Fever ☐ Tuberculosis
☐ Lung Disease ☐ Sinus Problems ☐ Venereal Disease
☐ Lupus ☐ Skin Disorder
☐ Measles ☐ Stroke

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

What is your method of birth control?

_____

Submit