KINGMAN FAMILY DENTISTRY

Date _____

Patient Account No. _____

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR **CHILD** START HERE

1

NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
EMAIL ADDRESS			
HOME PHONE NO.		CELL PHONE NO.	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			
DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

2 DENTAL INSURANCE

INSURANCE COMPANY
GROUP NO./AHCCS PLAN
EMPLOYEE
DATE OF BIRTH DATE EMPLOYED
UNION OR LOCAL NO.
EMPLOYEE NO./PATIENT ID.#
EMPLOYEE SOCIAL SECURITY NO.
INSURANCE COMPANY
GROUP NO./AHCCS PLAN
EMPLOYEE
DATE OF BIRTH DATE EMPLOYED
UNION OR LOCAL NO.
EMPLOYEE NO./PATIENT ID.#
EMPLOYEE SOCIAL SECURITY NO.

4 ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		

YOU

NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	

YOUR SPOUSE

NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	

3 GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

A. MAIN CONCERN

_____

B. DENTAL HISTORY

Frequency of visits to dentist and type of care received _____

Difficulties with past treatment or adverse reactions to local anesthetics, latex gloves, rubber dam _____

Date of most recent dental x-rays _____

C. MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No

   If yes, for what? _____

   Physician's Name _____ Phone _____

   Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, including over the counter medications & vitamins now? ..... Yes No

   If yes, please list name and dosage _____

4. Are you aware of having an **allergic (or adverse reaction)** to any medication or substance? ..... Yes No

   If yes, please list: _____

5. Have you been a patient in the hospital or had any surgeries during the past five years? ..... Yes No

   If yes, please list: _____

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

7. Are you now using or have you ever used tobacco products? ..... Yes No

   What kind of tobacco do you use? _____

8. Have you quit using tobacco? ..... Yes No Date last used tobacco _____
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No

   If yes, please list: _____

10. **Women**. Are you: **Pregnant?** Yes ___ Months No **Nursing?** Yes No **Taking birth control pills?** 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 provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

All charges incurred in our office are payable at the time of service unless prior arrangements have been made. All accounts in collection will be subject to collection fees.

Patient/Guardian Signature _____ Date _____

_____ Date _____