



# PATIENT REGISTRATION

**Welcome!** Please complete the following confidential information

## PATIENT INFORMATION

NAME \_\_\_\_\_  
(First) (Middle) (Last)

WHO MAY WE THANK FOR REFERRING YOU TO US? \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE \_\_\_\_\_ EXT \_\_\_\_\_

RELATIONSHIP TO INSURANCE SUBSCRIBER (The person in your family who your insurance is through):  Self  Spouse  Child  Other

## PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: \_\_\_\_\_ GROUP/POLICY # \_\_\_\_\_

NAME OF SUBSCRIBER \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
(First) (Middle) (Last)

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ MARITAL STATUS:  Married  Single  Other WORK PHONE \_\_\_\_\_ EXT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

## SECONDARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: \_\_\_\_\_ GROUP/POLICY # \_\_\_\_\_

NAME OF SUBSCRIBER \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
(First) (Middle) (Last)

DATE OF BIRTH \_\_\_\_\_ MARITAL STATUS:  Married  Single  Other WORK PHONE \_\_\_\_\_ EXT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

## CONSENT:

- ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** By signing below I acknowledge that I have received and reviewed a copy of this office's Notice of Privacy Practices according to federal and state requirements and I consent to the use of my records and information to carry out treatment, payment activities, and health care operations as set forth in this office's Privacy Notice.
- I hereby authorize Dr. Thomas C. Kelley or designated staff to take X-rays, photographs and any other diagnostic aids deemed appropriate by Dr. Thomas C. Kelley to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. Thomas C. Kelley to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary.
- I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Dr. Thomas C. Kelley. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the Dr. Kelley has a contractual agreement with my plan prohibiting all or a portion of such charges.
- By signing below, I certify that I read and write English and I have read, fully understand, and agree to the above items.



# MEDICAL HISTORY

**Welcome!** So that we may provide you with the best possible care, please complete both sides of this medical and dental history form. All information is completely confidential.

PATIENT'S NAME: \_\_\_\_\_

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

If yes, for what? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Are you currently taking any medications, drugs or pills? ..... Yes No

If yes, please list name and dosage: \_\_\_\_\_

\_\_\_\_\_

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? ..... Yes No

If yes, please list: \_\_\_\_\_

Circle Yes or No to indicate whether or not you have had or now have the following conditions or treatments:

- |   |  |   |
|---|--|---|
| Heart Condition ..... Yes / No            | Contact Lenses ..... Yes / No            | Cortisone Medicine ..... Yes / No             |
| Heart Attack ..... Yes / No               | Glaucoma ..... Yes / No                  | Arthritis/Rheumatism ..... Yes / No           |
| Heart Surgery ..... Yes / No              | Bruise Easily ..... Yes / No             | Fen-Phen or Redox ..... Yes / No              |
| Chest Pain (Angina) ..... Yes / No        | Emphysema ..... Yes / No                 | Special or Restricted Diet ..... Yes / No     |
| Congenital Heart Disease ..... Yes / No   | Chronic Cough ..... Yes / No             | Latex Sensitivity ..... Yes / No              |
| Stroke ..... Yes / No                     | Tuberculosis (T.B.) ..... Yes / No       | Cancer ..... Yes / No                         |
| High Blood Pressure ..... Yes / No        | Asthma ..... Yes / No                    | Tumors ..... Yes / No                         |
| Mitral Valve Prolapse ..... Yes / No      | Hay Fever ..... Yes / No                 | Chemotherapy ..... Yes / No                   |
| Artificial Heart Valve ..... Yes / No     | Sinus Trouble ..... Yes / No             | Radiation Therapy ..... Yes / No              |
| Rheumatic Fever ..... Yes / No            | Allergies or Hives ..... Yes / No        | Neurological Disorders ..... Yes / No         |
| Heart Murmur ..... Yes / No               | Liver Disease ..... Yes / No             | Nervous/Anxious ..... Yes / No                |
| Heart Pacemaker ..... Yes / No            | Hepatitis Type ____ ..... Yes / No       | Epilepsy or Seizures ..... Yes / No           |
| Anemia ..... Yes / No                     | Yellow Jaundice ..... Yes / No           | Fainting or Dizzy Spells ..... Yes / No       |
| Hemophilia ..... Yes / No                 | AIDS ..... Yes / No                      | Psychiatric/Psychological Care .. Yes / No    |
| Ulcers ..... Yes / No                     | HIV Positive ..... Yes / No              | Kidney Trouble ..... Yes / No                 |
| Alcoholism ..... Yes / No                 | Venereal Disease ..... Yes / No          | Artificial Joints or Heart Valves... Yes / No |
| Drug Addiction ..... Yes / No             | Cold Sores/Fever Blisters ..... Yes / No | Sickle Cell Disease ..... Yes / No            |
| Diabetes ..... Yes / No                   | Blood Transfusion ..... Yes / No         | Osteoporosis..... Yes / No                    |
| Family History of Diabetes ..... Yes / No | Thyroid Problems ..... Yes / No          | Bone Disease or Bone Cancer... Yes / No       |
|   | Swollen Ankles ..... Yes / No            |   |

Do you have or have you had any disease, condition or problem not listed ..... Yes No

If yes, please list: \_\_\_\_\_

Have you ever had prolonged or unusual bleeding? ..... Yes No

Are you taking or have you ever taken any of the following medications: Aredia (pamidronate), Zometa (zoledronic acid), Bonfos (clodronate), Actonel (risedronate), Boniva (ibandronate), Fosamax (alendronate), Skelid (tiludronate), Didronel (etidronate)..... Yes No

Have you ever had a reaction to a local anesthetic? ..... Yes No

Do you use more than two pillows to sleep? ..... Yes No

Do you experience frequent thirst, frequent eating or frequent urination? ..... Yes No

**Women:** Are you pregnant?...Yes No If yes, due date: \_\_\_\_\_ Nursing?...Yes No Taking birth control pills?...Yes No

(Please complete the other side)



# DENTAL HISTORY

CURRENT GENERAL DENTIST \_\_\_\_\_

DATE OF LAST DENTAL VISIT \_\_\_\_\_ LAST DENTAL CLEANING \_\_\_\_\_ LAST FULL MOUTH X-RAYS \_\_\_\_\_

HOW OFTEN DO YOU HAVE DENTAL EXAMINATIONS? \_\_\_\_\_ Seldom \_\_\_\_\_ Less than annually \_\_\_\_\_ Annually \_\_\_\_\_ Twice Annually or More

HOW OFTEN DO YOU BRUSH YOU TEETH? \_\_\_\_\_ HOW OFTEN DO YOU FLOSS? \_\_\_\_\_

WHAT OTHER DENTAL AIDS DO YOU USE? (Mouthrinse, toothpick, etc.) \_\_\_\_\_

Have you ever had:

Periodontal Treatment (deep cleaning or gum surgery)? ..... Yes No..... If yes, when? \_\_\_\_\_

Oral Surgery (tooth removal)? ..... Yes No

Orthodontic Treatment (braces)? ..... Yes No ..... If yes, when? \_\_\_\_\_

Your teeth ground or the bite adjusted? ..... Yes No

A bite plate or mouth guard? ..... Yes No

Do you smoke or chew tobacco? ..... Yes No..... If yes, how much? \_\_\_\_\_

Do you clench or grind your teeth while awake or asleep? ..... Yes No

Has any of your family members experienced periodontal

disease (such as gum disease or gingivitis)? ..... Yes No..... If yes, which family members? \_\_\_\_\_

Have you noticed any loose teeth or a change in your bite? ..... Yes No \_\_\_\_\_

Do you mouth-breathe while awake or asleep? ..... Yes No

Does food tend to become caught in between your teeth? ..... Yes No..... If yes, where? \_\_\_\_\_

Do you have tired jaws, especially in the morning?..... Yes No \_\_\_\_\_

Do you regularly experience clicking, popping or pain in the jaw joints?..... Yes No

Do you have difficulty in opening or closing your mouth? ..... Yes No

Do you chew on objects such as pencils or bite your nails? ..... Yes No..... If yes, what objects? \_\_\_\_\_

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 yes, what is your main concern? \_\_\_\_\_

Have you ever had an upsetting dental experience? ..... Yes No..... If yes, please describe: \_\_\_\_\_

Have you ever been told you need to take premedication prior to dental treatment? \_\_\_\_\_

Please explain anything else about having dental treatment that you would like us to know? \_\_\_\_\_

*I understand that my medical and dental histories are necessary to provide me with periodontal care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, Dr. Thomas C. Kelley has my permission to ask the respective health care provider or agency, who may release such information to Dr. Kelley. I will notify Dr. Kelley of any change in my health and/or medication(s).*

**Patient/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_