Kimberly Park Dental
A·S·S·O·C·I·A·T·E·S PC
Dedicated to excellence in family dentistry

PATIENT INTRODUCTION
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

#1 ABOUT YOU

Today's Date _____

Name _____
LAST FIRST MI MR MRS MS DR

I prefer to be called _____

☐ Male ☐ Female SS# _____

Birthdate ____/____/____ Age _____

Home Address _____

_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home # _____ Cell/Other # _____

Work # _____ Ext _____ DL# _____

Email Address _____

Employer _____

Employer's Address _____

How long there? _____ Occupation _____

Where and when are best time to reach you? _____

Who may we **Thank** for referring you? _____

Other family members seen by us _____

Previous/Present Dentist _____
(Please Circle)

#2 SPOUSE INFORMATION

His/Her Name _____

Employer _____

Work # _____ Ext _____ Home _____

Birthdate _____ DL # _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name _____ Relation _____

Work # _____ Home # _____

Address _____

City _____ State _____ Zip _____

#3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group # (Plan, Local or Policy#) _____

Insured's Name _____ Relation _____

Insured's Birthday ____/____/____ Insured's SS # _____

Insured's Employer _____

Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group # (Plan, Local or Policy#) _____

Insured's Name _____ Relation _____

Insured's Birthday ____/____/____ Insured's SS # _____

Insured's Employer _____

#4 ACCOUNT INFORMATION

Person Responsible for Account _____

Work # _____ Ext _____ Home _____

Billing Address _____

Relationship _____ SS # _____

Employer _____ DL # _____

Closest relative not living with you _____

Their Name _____ Relation _____

Work # _____ Home # _____

Address _____

City _____ State _____ Zip _____

CONTINUED ON BACK OF FORM

Patient Name _____

Why have you come to the dentist today? _____

MEDICAL HEALTH

Name and address of Physician _____

Have you been under a physician's care during the past 2 years? _____ Date of your last physical _____

Have you ever had major surgery? _____

If female: Are you taking hormones or birth control? _____ Are you Pregnant or nursing? _____

Are you a smoker? _____ Do you use smokeless tobacco? _____

Are you now taking or have you taken any prescription drugs during the past year? _____

Please list _____

Are you allergic to: ☐ Codeine ☐ Dental Anesthetics ☐ Latex ☐ Penicillin ☐ Sulfa ☐ Tetracycline

Other _____

Have you had or do you now have:

	Yes	No		Yes	No
AIDS/HIV	[ ]	[ ]	Mitral Valve Prolapse	[ ]	[ ]
Allergies	[ ]	[ ]	Hearing Impairment	[ ]	[ ]
Arthritis	[ ]	[ ]	Hepatitis	[ ]	[ ]
Artificial Heart Valves Year _____	[ ]	[ ]	Herpes	[ ]	[ ]
Artificial Joints Year _____	[ ]	[ ]	High Blood Pressure	[ ]	[ ]
Asthma	[ ]	[ ]	Kidney Disease	[ ]	[ ]
Cancer Year _____ Type _____	[ ]	[ ]	Liver Disease	[ ]	[ ]
Chemo/Radiation Therapy Year _____	[ ]	[ ]	Organ Transplant	[ ]	[ ]
Diabetes	[ ]	[ ]	Pacemaker/Defibrillator	[ ]	[ ]
Dry Mouth	[ ]	[ ]	Pain in Jaw Joint	[ ]	[ ]
Epilepsy/Seizures	[ ]	[ ]	Rheumatic Fever	[ ]	[ ]
Heart Disease/Attack	[ ]	[ ]	Stroke	[ ]	[ ]
Heart Murmur	[ ]	[ ]	Tuberculosis (TB)	[ ]	[ ]

Have you any disease, condition, or problem not previously listed? _____

Date of last Dental Visit _____ Date of last x-rays _____

Are you having dental pain or discomfort at this time? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

The undersigned hereby authorizes 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 forms of treatment, medication and therapy, that may be indicated in connection with _____ (Name of patient) and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that 1.5% finance charge (18% annually) will be added to any balance over 90 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____