Stevensville Family Dentistry

PATIENT INFORMATION

~ Please print, complete and bring to your first appointment ~

Patient Name _____ Male _____ Female_____

Preferred to be called _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____/_____/_____ Age _____ Social Security Number _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Preferred Method of Contact _____ May we leave a message? Yes _____ No _____

Employer Name _____ Occupation _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Emergency Contact Name _____

Phone Number _____ Relationship to Patient _____

Preferred Pharmacy _____

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

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

Person Responsible for this Account _____

Relationship to Patient _____

Date of Birth _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

DENTAL INSURANCE INFORMATION

Primary-Policy Holder Name_____ Date of Birth _____

Employer _____ Group # _____ ID/SS# _____

Insurance Company Name _____

Secondary- Policy Holder Name_____ Date of Birth _____

Employer _____ Group # _____ ID/SS # _____

Insurance Company Name _____

I assign directly to Dr. Thomas Kirkdorfer all insurance benefits for services rendered. I understand that I am financially responsible for all charges, billing/interest fees whether the insurance pays or not. I authorize this office to release any information necessary to obtain the payment of benefits. This signature authorizes the use of all insurance claim submissions.

Responsible Party Signature _____ Date _____

DENTAL HISTORY

Patient Name_____ Date _____
Are you presently experiencing a dental problem? ____ If so, what is it? _____
Last dental visit?_____ For what treatment? _____
Last teeth cleaning?_____ Last full-mouth x-rays? _____ Where? _____
Previous dentist's name?_____ Phone # _____
Why did you leave your previous dentist?_____

Please Circle your answer, where appropriate, for the following questions: Y = Yes N = No

Have you ever had an accident involving head or jaw injuries? **Y N** _____
Have you had any teeth removed? **Y N** Why?_____
Have they been replaced? **Y N** What were they replaced with? _____
Are you unhappy with the replacement? **Y N** If yes, explain: _____
Have you had any complications with previous dental treatment? **Y N** _____
Do you clench or grind your teeth? **Y N** While you sleep? **Y N** Does your jaw pop or click? **Y N**
Have you experienced any pain or soreness in your face muscles or around your ear? **Y N** _____
Do you have frequent headaches or neck aches? **Y N** _____
When do you brush your teeth? _____ Toothpaste brand? _____
Do you floss your teeth? **Y N** When? _____ Any problem areas? _____
Do you get food caught between your teeth? **Y N** _____Do your gums bleed or hurt? **Y N** _____
Are any of your teeth sensitive to: Hot? **Y N** Where? _____
Cold? **Y N** Where?_____
Sweets? **Y N** Where? _____
Pressure? **Y N** Where? _____
Are any of your teeth loose, tipped, shifted, or chipped? **Y N** _____
Do you feel your breath is offensive at times? **Y N**_____
Do you use any of these products? ❑ electric toothbrush ❑ water-pik ❑ bridge threaders
❑ floss holders ❑ mouthwash (brand) _____ ❑ toothpicks
What is your drinking/cooking water supply? ❑ well ❑ municipal (from where?) _____
Have you ever had: Gum surgery? **Y N** _____
Orthodontics (braces)? **Y N** _____
Root canal treatment? **Y N** _____
Surgery in or around the mouth? **Y N**_____
Do you wear any removable appliances? ❑ bite splint ❑ retainer: upper lower ❑ snore appliance
❑ complete denture: upper lower Leave out at night? **Y N** First one? **Y N** How old is it? _____
❑ partial denture: upper lower Leave out at night? **Y N** First one? **Y N** How old is it? _____
Do you use any adhesive? **Y N** What do you use to clean appliance? _____
Are you having any specific problem with the appliance?_____
Do you usually have a local (injection) anesthetic for dental work? **Y N** _____ Teeth cleaning? **Y N**
Interested in having something to relax you during treatment? **Y N** Ever try: "Laughing Gas"? **Y N**
Like instruction on how to take better care of your teeth? **Y N** ❑ brushing ❑ flossing ❑ other _____
Ever have an unpleasant dental experience or is there an aspect about dentistry you strongly dislike?

_____
Do you have any questions or concerns?_____
_____
_____
_____

Patient Name_____ Date _____ *[Dental History Continued]*

Please check one box in each section:

❑ My mouth is very comfortable
❑ My mouth is moderately comfortable
❑ My mouth is uncomfortable

❑ I think the appearance of my smile is excellent
❑ I am satisfied with the appearance of my smile
❑ I would like to change my smile
❑ I am unconcerned about the appearance

❑ I will do whatever I must to keep my teeth
❑ I want to keep my teeth but only within a certain budget of time and money
❑ I am indifferent about keeping my teeth

❑ I have always done what was recommended to me
❑ I have done most of what was recommended but have not completed some procedures
❑ I have not done what was recommended to me

❑ I put dental care high on my list for myself
❑ I put dental care low on my list
❑ I have never considered where I put dental care

❑ I think my present state of dental health is excellent
❑ I think my present state of dental health is good
❑ I think my present state of dental health is poor

Obstacles I see to having excellent dental care for myself:

If you select more than one of the following, please number them in order of significance with #1 being that which is most significant for you at this time.

_____ I see no obstacles

_____ Time away from work or other obligations

_____ Fear of pain, surgery, or injections

_____ The cost of treatment

_____ Other _____

MEDICAL HISTORY

Patient Name _____ Date _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATIONS THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL RECEIVE. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

Please Circle your answer, where appropriate, for the following questions: Y = Yes N = No

Are you now or have you recently been under a Physicians Care? **Y N** If yes, please explain:

_____

Have you been Hospitalized or had a Major Operation within the last 5 years? _____

_____

Name of Regular Care Physician:_____

Name of Specialists and Specialty:_____

_____

Have you ever been told to Pre-Medicate with Antibiotics BEFORE a Dental Procedure? **Y N**

Are you currently taking any drugs, medications or pills? **Y N** If yes, please provide a current list:

_____

_____

Do you take, or have you taken: Diet Pills, Fen-Phen or Redux? **Y N** _____

Are you taking or ever taken: Fosomax, Boniva, Actonel or any other Bisphosphonates? **Y N**

Are you on Blood Thinners? **Y N** Aspirin, Coumadin, Eliquis, Pradaxa, Xarelto, Plavix, Other: _____

Are you on a Special Diet? **Y N** _____

Are you Allergic to any Foods, including Cloves? **Y N** Explain: _____

Do you use any Controlled Substance? **Y N** Explain: _____

Do you use Tobacco? **Y N** ❑ Smoke ❑ Chew ❑ E-Cig ____ # PACKS / DAY ____

_____

Women: Are you Pregnant / trying to get Pregnant? **Y N** Explain: _____

Taking Oral Contraceptives? **Y N** Nursing? **Y N** Explain: _____

Are you Allergic to any of the Following?

❑ Aspirin ❑ Local Anesthetics ❑ Latex ❑ Erythromycin ❑ Penicillin ❑ Acrylic ❑ Sulfa Drugs

❑ Nitrous Oxide ❑ Codeine ❑ Metal ❑ Iodine ❑ Other-explain: _____

Do you have, or have you had, any of the following? Please Circle:

Heart Trouble / Heart Attack	Swelling of Feet / Ankle / Hands	Stroke / TIA
Shortness of Breath	High Cholesterol	Heart Murmur / Rheumatic Fever
Anemia / Bruise Easily	Blood Disorders	Pacemaker (w/ Defibulator?)
HIV Positive / AIDS Complex	Asthma	Blood Transfusion
Artificial Heart Valve	Abnormal Bleeding / Hemophilia	Shingles
Mitral Valve Prolapse (MVP)	Hepatitis: A, B, C, D	Liver Disease
Tuberculosis	Heart Surgery / Stents	Coughing Blood / Lung Disease
Congenital Heart Disease	Hay Fever / Allergies	Breathing Problems
High (Or Low) Blood Pressure	COPD / Emphysema	Frequent Cough
Irregular Heart Beat / AFIB	Sinus Problems	Angina / Pain In Chest

Patient Name_____ Date _____ *[Medical History Continued]*

Glaucoma	Diabetes	Seizures / Epilepsy
Kidney Trouble / Renal Disease	Excessive Urination	Prolonged Healing
Fainting Spells / Dizziness	Excessive Thirst	Parathyroid Disease
Convulsions	Hypoglycemia	Thyroid Disease
Cortisone Therapy	Acid Reflux / GERD	Stomach / Intestinal Disease
Crohn's Disease	Stomach Ulcers	Frequent Vomiting
Irritable Bowel Syndrome	Blindness (Left / Right)	Hearing Difficulties
Eating Disorder / Bulimia	Rheumatoid (or Osteo) Arthritis	Fibromyalgia
Earaches	Drug Addiction	Venereal Disease
Herpes	Alcoholism	Intellectual Disabilities
Cold Sores / Fever Blisters	Alzheimer's / Dementia	Developmental Disabilities
Autism	Depression	Attention Deficit Disorder
Cognitive Disorder	Mental Health Care	Nervous Disorder
Cancer / Type_____	Tumors / Growths	Artificial Joint Replacement:
Radiation Treatment	Chemotherapy	Hip, Knee, Thumb, Toe,
Osteoporosis / Osteopenia	Psychiatric Care	Shoulder, _____
Sleep Apnea / C-PAP / Snore Appl	_____	_____

Any other Diseases or Conditions not mentioned above? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the Stevensville Family Dentistry Dental Office of any changes in medical status.

Responsible Party Signature _____ Date _____
(Patient, Parent or Guardian)

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For Office Use:

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