Kingsland Family Dental
Registration and Medical History

Date:_____ **Patient Information**

Patient Name:_____ DOB:_____/_____/_____ Age_____
Last First M
Social Security#_____-_____-_____ Sex: ___M ___F

Marital Status: Single Married Child Other Spouse or Parent Name:_____

Street Address:_____
City St Zip

(Home)(_____)_____-_____ (Work)(_____)_____-_____ (Cell)(_____)_____-_____

Email Address:_____

Medical History

Primary Care Physicians:_____ Date of Last Physical:_____
Have you ever had any of the following? (**Please check all that apply**)

___Arthritis	___Epilepsy	___Mitro Valve Prolapse
___Artificial heart valves, joints, stents,…	___Headaches	___Nervous Problems
___Asthma	___Heart Murmur	___Pacemaker
___Back Problems	___Heart Problems	___Radiation Treatment
___Bleeding Abnormally	___Hepatitis, A, B, or C	___Recent Weight Loss
___Blood Disease	___Hernia Repair	___ Respiratory Problems
___Blood Thinners (Aspirin, Coumadin, Plavix)	___High Blood Pressure	___ Rheumatic Fever
___Cancer (type) _____	___HIV/AIDS	___Seasonal Allergies/Sinus
___Circulatory Problems	___Jaundice or Liver Disease	___Stroke
___Congenital Heart Lesions	___Latex Allergy	___Swollen Neck Glands
___Diabetes type I or II	___Low Blood Pressure	___Venereal Disease

If you check any of the above please explain:_____
_____
Have you ever had to **Pre-Med** before a dental treatment? **Yes or No** , If yes, what?_____
Do you have any **drug allergies**? **Yes or No** , If yes please list:_____
Have you ever had an adverse reaction to any medication or anesthesia? **Yes or No** , If yes, what?_____
_____
Have you ever taken any of the drugs Fosamax or Boniva? **Yes or No**
Are you under the care of a physician? **Yes or No** , If yes, for what?_____
_____
If the patient is a child, what is his/her weight? _____lbs
(Women) Do you suspect that you are pregnant? **Yes or No** Due Date:_____ Are you nursing? **Yes or No**
Is there anything else we should know about you medical history? _____

_____

Signature **Date**

Kingsland Family Dental
Registration and Medical History

Patient Medications

Patient Name:_____ **DOB:**_____
(Please Print)

PLEASE LIST ALL CURRENT MEDICATIONS:

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the office at the next appointment without fail.

_____ _____
Signature **Date**

Kingsland Family Dental
Dental History

Patient Name:_____ DOB:_____/_____/_____

What is the reason for your visit today?_____

Date of last dental visit _____ Last dental cleaning_____ Last full mouth X-rays_____

What was done at your last dental visit?_____

Previous Dentist's Name:_____

Address:_____

City State Zip

How often do you have dental exams/cleanings? 3months 4months 6months other:_____

How often do you brush? _____ How often do you floss? _____

What other dental aids do you use? Waterpik Electric toothbrush Other: _____

Do you have any dental problems now? Yes No If yes, please list:_____

Are any of you teeth sensitive to:

Hot or cold Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad taste? Yes No

Do you frequently get cold sores, blisters or any other lesions? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Bite Adjustment? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

Have you ever experienced:

Clicking or popping of the jaw? Yes No

Pain (joint, ear side of face)? Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neck aches or shoulder aches? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth for the rest of your life? Yes No

Do you:

Clench or grind your teeth while awake or asleep? Yes No

Bite your lip or cheeks regularly? Yes No

Mouth breathe while awake or asleep? Yes No

Hold foreign objects with teeth (pens, pencils or fingernails)? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have any other sleeping disorders? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you ever noticed any loose teeth or change in your bite? Yes No

Smoke/Chew tobacco or use other tobacco products? Yes No

Do you use alcoholic beverages? Yes No How much?_____ How long?_____

How would you rate you smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please explain:_____

_____

Kingsland Family Dental
Responsible Party and Insurance Information

Responsible Party Information

Name: _____ DOB: _____/_____/_____
Last First Middle

Social Security#_____-_____-_____ Sex: _____M _____F Marital Status: Single Married Other

Street Address: _____
City State Zip

Home (_____) _____-_____ Work (_____) _____-_____ Cell (_____) _____-_____

Email Address: _____

Primary Dental Insurance Information

Primary Insurance Company: _____ Phone: (_____)_____-_____

Address:_____
City State Zip

Member No._____ Group No._____

Name of Policy Holder: _____ DOB: _____/_____/_____
Last First Middle

Social Security#_____-_____-_____ Sex: _____M _____F Marital Status: Single Married Other

Patient relationship to insured: Self Spouse Parent Child Other

Primary Policy Holder Employment Information

Name of Employer:_____ Occupation:_____

Employer address:_____ Phone: (____) _____-_____

Kingsland Family Dental
Responsible Party and Insurance Information

Secondary Dental Insurance Information

Secondary Insurance Company: _____ Phone: (_____)_____-_____

Address:_____
City State Zip

Member No._____ Group No._____

Name of Policy Holder: _____ DOB: _____/_____/_____
Last First Middle

Social Security#_____-_____-_____ Sex: _____M _____F Marital Status: Single Married Other

Patient relationship to insured: Self Spouse Parent Child Other

Secondary Policy Holder Employment Information

Name of Employer:_____ Occupation:_____

Employer address:_____ Phone: (____) _____-_____

Kingsland Family Dental
18 Hawthorne Lane, Suite A
St. Marys, Georgia 31558

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plait and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed, by you, of your Notice of Privacy Practices; containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PRINT PATIENT NAME: _____

PRINT PARENT/GUARDIAN NAME:_____

SIGNATURE: _____

DATE: _____