GRETCHEN KINCHEN, DMD **PATIENT INFORMATION**

Today's Date _____/_____/_____

Patient's Name _____
First MI Last

Please let us know if you have a nickname or preferred name by which you wish to be called. _____

Sex ☐ M ☐ F Date of Birth _____/_____/_____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Address _____
Street City State Zip

Phone # (_____) _____ (_____) _____ (_____) _____
Home # Work # Mobile #

Social Security # _____ E-mail Address _____

Are you a full time student? ☐ Yes ☐ No If yes, School Name _____

Employer _____
Name Address City State Zip

Has any member of your family been treated in our office? ☐ Yes ☐ No If so, who? _____

How did you hear about our office? _____

Contact in case of emergency _____ (_____) _____
Name Relationship Phone #

☐ Spouse *or* ☐ Parent, if minor _____ (_____) _____
Name Address Phone #

Person Responsible for Account _____
Name Relationship SS#

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Relationship to Patient _____
First MI Last

Subscriber's ID # _____ Subscriber's Date of Birth _____/_____/_____

Subscriber's Employer _____
Name Address City State Zip

We will need to copy your insurance card *or* please provide us with the following information so we may verify coverage:

Insurance Company _____
Name Address City State Zip

Insurance Company Phone # (_____) _____ Group # _____ Local Union #, if any _____

I authorize this office to perform diagnostic procedures (examination, x-rays, study models and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatment needs.

Patient, Parent or Guardian Signature _____ Date _____/_____/_____

I understand this office may photograph my face and mouth for purpose of documentation in my patient chart. _____ (Initial)
I further grant my permission for this office to use my photographs for purposes of educating other patients, including placing them on our website.

Patient, Parent or Guardian Signature _____ Date _____/_____/_____

GRETCHEN KINCHEN, DMD **MEDICAL HISTORY**

Today's Date _____/_____/_____

Patient's Name _____ Date of Birth _____/_____/_____

Are you under a physician's care now? ☐ Yes ☐ No If so, for what? _____

_____

Physician's Name _____ Phone # (_____) _____

Are you taking (or supposed to be taking) any medications, vitamins or herbal supplements? ☐ Yes ☐ No Please list below

_____

_____

_____

Are you pregnant? ☐ Yes ☐ No If yes, due date _____

Do you use tobacco in any form? ☐ Yes ☐ No _____

Have you ever taken or are you currently taking any bisphosphonates such as Zometa, Fosamax, Aredia, Actonel, Boniva Didronel, Skelid, Bonefos, or alendronate? ☐ Yes ☐ No

Are you allergic to any medications or substances? ☐ Yes ☐ No If yes, please check boxes below.

☐ Aspirin ☐ Penicillin ☐ Sulfa Drugs ☐ Codeine

☐ Latex or Rubber ☐ Other _____

Have you ever had a reaction or experienced complications to any dental treatment in the past? ☐ Yes ☐ No

Please check "yes" if you presently have or have had in the past any of the following conditions:

Yes		Yes		Yes	
☐	Heart Trouble/Disease	☐	Lung or Breathing Problems	☐	Severe Headaches
☐	Heart Murmur*	☐	Shortness of Breath	☐	Fainting or Dizzy Spells
☐	Irregular Heart Beat	☐	Sinus Trouble	☐	Epilepsy, Seizures or Convulsions
☐	Angina or Chest Pain	☐	Asthma	☐	Psychiatric Care
☐	Heart Attack or Failure	☐	Chronic Cough	☐	Hepatitis, Jaundice or Liver disease
☐	Congenital Heart Disorder	☐	Emphysema	☐	Arthritis, Gout or Rheumatism
☐	Mitral Valve Prolapse*	☐	Tuberculosis (TB)	☐	Artificial Joint*
☐	Rheumatic Fever*	☐	Frequent Sore Throat	☐	Night Sweats
☐	Artificial Heart Valve*	☐	Tumor or Cancer	☐	Stomach or Intestinal Disease
☐	Heart Pacemaker*	☐	X-ray or Cobalt Treatment	☐	Thyroid Disease
☐	Heart Surgery	☐	Chemotherapy	☐	Kidney or Bladder Problems
☐	Stroke	☐	Enlarged Lymph Nodes (Glands)	☐	Renal Dialysis
☐	Aneurysm	☐	Swelling of Limbs	☐	Hypoglycemia
☐	High Blood Pressure	☐	Bruise Easily	☐	Frequent Diarrhea
☐	Low Blood Pressure	☐	HIV Positive or AIDS	☐	Glaucoma or Eye Problems
☐	Bleeding Disorder	☐	Sexually Transmitted Diseases	☐	Excessive Thirst
☐	Blood Transfusion	☐	Major surgery	☐	Diabetes

_____

Have you ever had any other disease, problem or condition not listed above? ☐ Yes ☐ No Discuss _____

_____

Do you wish to speak privately to the dentist about any problems? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or my child) ever have any change in health status or medications being taken or if I (or my child) have any abnormal medical test results, I will inform the dentist at the next appointment without fail.

Patient, Parent or Guardian Signature _____ Date _____