PATIENT REGISTRATION AND HEALTH HISTORY

Welcome to our office. Please provide the following information.
It is important for our records and your health.

KIRKLAND DENTISTRY
FAMILY & COSMETIC
DAVID RICHARDSON DDS

PATIENT INFORMATION:

NAME (Mr/Mrs/Ms) _____ Birthdate ____/____/____ Age _____ SSN _____

Residence Address_____ Mailing _____

City_____ State_____ Zip_____ Home Phone _____

Occupation_____ Cell Phone _____

Employer_____ Business Phone _____

Business Address_____ City_____ State _____ Zip _____

Email _____ Driver's License # _____

Whom may we thank for referring you?_____

SPOUSE INFORMATION:

Name (Mr/Mrs/Ms) _____ SSN _____ Cell Phone _____

Occupation _____ Employer _____ Business Phone _____

Business Address _____ City _____ State _____ Zip _____

RESPONSIBLE PARTY IF PATIENT IS A MINOR: _____ Relationship to Minor_____

Address (if different than above) _____ Phone _____

Emergency Contact: _____ Phone _____

PRIMARY INSURANCE

Employee Name _____ Employer _____

Insurance Co_____ Program or Policy #_____

Union Local or group _____ Employee SS#_____ Birthdate_____/_____/_____

SECONDARY INSURANCE

Employee Name _____ Employer _____

Insurance Co_____ Program or Policy #_____

Union Local or group _____ Employee SS#_____ Birthdate_____/_____/_____

ASSIGNMENT & RELEASE: I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due AT TIME OF SERVICE. I also authorize the dentist to release any information required for this claim. We cannot accept responsibility for collecting an insurance claim or for negotiating disputed claims. **YOU** are **RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT.** Insurance Reimbursement is a contract between you and your insurance company. In consideration of the service rendered to me by this dental office, I am obliged to pay said office in accordance with its credit terms and policy.

Kirkland Dentistry requires cancellation of appointments at least 24 business hours in advance to avoid charges.

Patient's Signature _____ **Financially Responsible Party Signature** _____ **Date** ___/___/___

Guardian Signature (if patient a minor) _____ **Date** ___/___/___

DENTAL HISTORY

Yes / No	Head or neck injuries	Yes / No	Anxiety of dental treatment	Yes / No	Reactions to "Novocain"
Yes / No	Sore or sensitive teeth	Yes / No	Sores on lips/mouth that are slow to heal	Yes / No	Bleeding /slow healing after an extraction
Yes / No	Bleeding gums	Yes / No	Orthodontic treatment	Yes / No	Dissatisfaction with the appearance of your teeth
Yes / No	Grind or clench teeth	Yes / No	Periodontal Disease (Pyorrhea)	Yes / No	Trouble opening/closing your jaw
Yes / No	Difficulty chewing	When was your last dental X-ray? _____			

PRIOR DENTIST: Name _____ Phone _____

MEDICAL HISTORY

_____

Your Physician

_____

Phone

DO YOU HAVE OR HAVE YOU EVER HAD : (Circle)

Yes / No Asthma

Yes / No Hospitalization for illness or surgery

Yes / No An allergic reaction

Yes / No Emotional problems or tension

Yes / No A tumor or abnormal growth

Yes / No AIDS (Acquired Immune Deficiency Syndrome)

Yes / No A stroke

Yes / No Hepatitis

Yes / No Epilepsy

Yes / No Anemia or other blood disorders

Yes / No Often thirsty

Yes / No Kidney disease

Yes / No Diabetes

Yes / No Liver disease

Yes / No Heart trouble or murmur

Yes / No Chest pain on mild exertion

Yes / No High blood pressure

Yes / No Low blood pressure

ARE YOU:

Yes / No Presently being treated for any illness

Yes / No Taking any medication regularly now or within the past year

Yes / No Aware of a change in your general health in the past year

Yes / No Ever been told that you stop breathing while asleep

Yes / No Currently using CPAP machine

Yes / No Sleepy, exhausted or fatigued during your day

Yes / No Ever been told that you snore

Yes / No Subject to frequent headaches or wake with a headache

Yes / No Often unhappy and depressed

Yes / No Smoking ____ cigarettes a day

FEMALE, ARE YOU NOW:

Yes / No Pregnant

Yes / No Taking birth control pills or other hormones

Yes / No Presently in menopause ("change of life")

Yes / No Past menopause

PLEASE EXPLAIN ANY YES ANSWERS ABOVE:

_____

_____

_____

IF THERE ARE ANY CHANGES IN MY MEDICAL HISTORY, I WILL NOTIFY THE DENTIST

PATIENT (or Guardian) SIGNATURE _____ DATE _____/_____/

FOR OFFICE USE

Reviewed by _____Date ____/____/____ Reviewed by _____Date ____/____/____

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