Welcome

K FAMILY
Dentistry

ABOUT YOU

Today's Date:_____ Reason for your visit?_____

Patient's Name_____ Nickname:_____

Address:_____ City/Zip:_____

Date of Birth:_____ Phone (Cell):_____ (Home):_____

Social Security Number:_____ Email:_____

Whom may we thank for referring you?_____

RESPONSIBLE PARTY INFORMATION

Name:_____ Phone (Primary)_____

Date of Birth:_____ Relationship to Patient:_____

DENTAL INSURANCE INFORMATION

Name of Policy Holder_____ SSN:_____

Date of Birth:_____ Employer's Name_____

Insurance Company:_____ ID Number:_____

Do You Have Other Dental Coverage? ☐ Yes ☐ No

If Yes, Name of Policy Holder:_____ Date of Birth:_____

Social Security Number_____ Employer's Name_____

ID Number:_____ Insurance Company:_____

EMERGENCY CONTACT INFORMATION

Friend or Relative Not Living With You:_____

Phone (Primary):_____

SIGNATURE_____ DATE:_____

(Parent if Patient is a Minor)

Health History on Back of this Page

Turn Over

3456 E 12 Mile Road, Warren MI 48092 | (586) 486-4600 | kfamilydentistry@gmail.com

WHAT IS THE REASON FOR THIS VISIT? _____

Who is your personal physician _____ Doctor's office location _____

Date of last complete physical exam _____ Doctor's phone number _____

Please check "YES" or "NO"	YES	NO
Are you in good health?	___	___
Are you currently under medical care?	___	___
(If so, for what?) _____		
Do you take any medications regularly?	___	___
(If so, what are they?) _____		
Have you ever been premedicated for dental treatment?	___	___

Please check "YES" or "NO"	YES	NO
Are you aware of any changes in your health in the past year?	___	___
Comment: _____		
Have you ever been hospitalized?	___	___
(If so, for what) _____		

Do you have or have you ever been treated for any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
Heart Disease / Attack	☐	☐	Mitral Valve Prolapse	☐	☐	Epilepsy	☐	☐	Any liver problems	☐	☐
Angina Pectoris	☐	☐	Heart Murmur	☐	☐	Arthritis	☐	☐	Excessive bleeding	☐	☐
Coronary Surgery	☐	☐	Congenital Heart Lesion	☐	☐	Asthma	☐	☐	Do you smoke	☐	☐
Artificial Heart Valve	☐	☐	Anemia	☐	☐	Emphysema	☐	☐	a. How much a day	_____	
Heart Pacemaker	☐	☐	Diabetes	☐	☐	Hay Fever / Allergies	☐	☐	Do you chew tobacco	☐	☐
High Blood Pressure	☐	☐	Hepatitis B (Serum)	☐	☐	Bleeding Disorder	☐	☐			
Low Blood Pressure	☐	☐	Hepatitis A (Infectious)	☐	☐	Venereal Disease	☐	☐			
Arteriosclerosis	☐	☐	Jaundice	☐	☐	HIV Positive (AIDS)	☐	☐			
Stroke	☐	☐	Kidney Disease	☐	☐	I am on dialysis	☐	☐			
Rheumatic Fever	☐	☐	Tuberculosis	☐	☐	Radiation Treatment	☐	☐			

Have you ever experienced a rash, itching, or other reaction after use of any of these medications?

	YES	NO		YES	NO
Aspirin	___	___	Penicillin	___	___
Local Anesthetics	___	___	Erythromycin	___	___
Codeine	___	___	Tetracycline	___	___
Sedatives	___	___	Other Antibiotics	___	___
Lodine	___	___	Sulfa	___	___

Others? _____

_____

_____

_____

Do you have, or have you experienced	YES	NO
A. Shortness of breath on mild exertion	___	___
B. Chest pains after/during exertions	___	___
C. Swollen Ankles	___	___
D. Emotional problems, stress, or tension which cause you concern	___	___
E. A tumor or abnormal growth	___	___
F. Have you ever had counseling for stress	___	___
G. Do you have dry mouth	___	___
H. Have you had any serious trouble at any previous dental visits	___	___
I. Are you wearing contact lenses	___	___
J. Any artificial replacements	___	___
LADIES		
1. Are you pregnant	___	___
2. Do you take birth control pills	___	___
3. Do you take estrogens or hormones	___	___

(For office use only):

3456 E 12 Mile Road, Warren MI 48092 | (586) 486-4600 | kfamilydentistry@gmail.com