Kenneth E. Kay, DMD, MAGD

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date____________________________

Patient______________________________________

Address _____________________________________

____

____

City State Zip

Sex: ☐ M ☐ F Age_______Birthdate _______________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# __________________________________

Occupation___________________________________

Employer____________________________________

Employer Address ____________________________

Employer Phone # ____________________________

Spouse's/Parent's Name _______________________

Birthdate____________________________________

SS#____

Occupation___________________________________

Spouse's/Parent's Employer ____________________

Whom may we thank for referring you? ___________

____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ___________________________ and assign directly to Dr. Kenneth E. Kay all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature / Relationship Date

DENTAL INSURANCE

PRIMARY INSURANCE

Insurance Company ___________________________

Group # ____________________________________

Employer:___________________________________

Subscriber's Name ___________________________

Birthdate____________________SS#______________

Relationship to Patient _______________________

SECONDARY INSURANCE

Insurance Company ___________________________

Group # ____________________________________

Employer:___________________________________

Subscriber's Name ___________________________

Birthdate____________________SS#______________

Relationship to Patient _______________________

FINANCIAL INFORMATION

Who is responsible for the account? ____________________

Relationship to Patient: ____________________

I understand that I am responsible for all charges. I understand that I must give 24 hours notice of an appointment change in order to avoid a broken appointment fee of $50.00.

Signature_______________________Date ___________

3. PHONE NUMBERS

Home_______________Work_____________Ext________Cell______________Spouse's/Parents Work _________________

Email Address ____

IN CASE OF EMERGENCY, CONTACT (*include one person not living in your household*)

Name____Phone Number ______________________

Name____Phone Number ______________________

DENTAL HISTORY

Reason for today's visit: ______________________________
____
Date of last dental x-rays: ______________________________
Do you have/have you had any of the following?

- ☐ Bad Breath
- ☐ Bleeding/Tender gums
- ☐ Food collection between teeth
- ☐ Orthodontic treatment
- ☐ Periodontal/gum treatment
- ☐ Sensitivity hot/cold
- ☐ Teeth grinding/clenching
- ☐ Ulcers/cold sores
- ☐ Jaw problems

How often do you brush? ___________ Floss? ___________

Are you interested in any of the following dental treatment?

- ☐ Whiter teeth/bleaching
- ☐ Cosmetic changes to your teeth
- ☐ Replacing missing teeth
- ☐ Other ____

Describe other dental problems or concerns: ___________________
____
____
____

HEALTH HISTORY

Physician's Name:____Date of last visit: ____________________________

Are you under medical treatment now? ☐Yes ☐ No If yes, for what? ____

Please check "Yes" or "No" to indicate if you have had any of the following:

Anemia	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Heart &/or Valve Problems	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Hepatitis (Type__________)	☐ Yes ☐ No	Skin Rash/Hives	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swelling of Feet or Ankles	☐ Yes ☐ No
Bleeding abnormally,		HIV Positive	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
with extractions or surgery	☐ Yes ☐ No	Infective Endocarditis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Bone Density/Osteoporosis	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Born with heart defect	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tumor or growth on	
Chemical Dependency	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	head or neck	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	VD/STD	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Weight Loss, Unexplained?	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Are you taking blood	
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	thinners? (Aspirin, etc.)	☐ Yes ☐ No
Emphysema/COPD	☐ Yes ☐ No	Pulmonary Shunt	☐ Yes ☐ No	Women:	
Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No	Due Date ______	
Glaucoma	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Are you nursing?	☐ Yes ☐ No

Are you on any bone building drugs for bone density issues/osteoporosis (Boniva, Fosamax, Actonel, Reclast, etc.) ☐ Yes ☐ No

List any other medical conditions you have ____

MEDICATIONS

List any medications you are currently taking

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____

____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex (Gloves)
- ☐ Local Anesthetic
- ☐ Penicillin/Amoxicillin
- ☐ Sulfa
- ☐ Other __________________

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I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge and understand that I am responsible for notifying this office of any changes in my medical condition. I hereby give my consent to the dentist to perform an examination and diagnose my condition and to perform any preventative or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Signature: ____ Date: __________________________