Medical History Form

Date ____________________________

Name ___________________________ _________________________ ____________ Home Phone (______) ________________
Last (Please print) First Middle

Address ____ Work Phone (______) ________________

City ____________________________________ State ______ Zip Code ____________ Cell Phone (______) ________________

E-Mail Address____ Social Security # ________________________

Sex M F Date of Birth ___/___/___ Height _____ Weight_____ Married __ Single __ Child ___ Other ___________________

Name of Spouse ________________________ Closest Relative __________________________ Phone (______) _______________

Other Family Members Currently Patients? ____

Referral Information

Whom may we thank for referring you to our practice? ____Another patient, friend ____Another patient, relative

___Dental Office ____Yellow Pages ____ School ____ Work ____ Insurance List Other ____________________________

Name of person or office referring you to our practice:____

HEALTH INFORMATION

For the following questions, please check whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Have you ever had any of the following?

___ Aids+/HIV
___ Allergies _________________
____
___ Anemia
___ Arthritis
___ Artificial Joints
___ Asthma
___ Blood Disease
___ Blood Transfusion
___ Cancer
___ Cardiovascular Disease
___ Diabetes
___ Difficulty Breathing
___ Dizziness
___ Drug/alcohol Abuse
___ Epilepsy/Seizures
___ Excessive Bleeding

___ Fainting
___ Glaucoma
___ Hay Fever
___ Head Injuries
___ Heart Disease
___ Heart Murmur
___ Hepatitis
___ High Blood Pressure
___ Hypo/Hyper Thyroid
___ Jaundice
___ Kidney Disease
___ Liver Disease
___ Low Blood Pressure
___ Mental Disorders
___ Mitral Valve Prolapse
___ Nervous Disorders
___ Pacemaker

___ Pregnancy Due Date _______
___ Respiratory Problems
___ Rheumatic Fever
___ Rheumatism
___ Sinus Problems
___ Smoker / Tobacco use
___ Stomach Problems
___ Stroke
___ Tuberculosis
___ Tumors
___ Ulcers
___ Venereal Disease

Are you allergic to:

Codeine Aspirin
Local Anesthetics Iodine
Sulfa Drugs Penicillin
Other _______________________

Do you require any pre-medications prior to dental treatment? Yes No
Have you ever had any complications following dental treatment? Yes No
If yes, please explain:____
Are you wearing removable dental appliances? Yes No
Have you been admitted to a hospital or needed emergency care during the past five years? Yes No

If yes, Please explain:____

Do you have any disease, condition, or problem not listed above that you think I should know about?

Yes No Please explain:____

Are you under the care of a physician? Yes No Physician's name & number ____

If yes, what is the condition being treated?____

Are you taking any medicine(s) including non-prescription medicine, drugs or alcohol? Yes No

If yes, what medicine(s) are you taking?____

____

(Please use a separate sheet of paper to list additional medications or information that does not fit on this form.)

RESPONSIBLE PARTY INFORMATION

Name: ____________________________________ Male / Female Relationship to Patient: _____________________
Social Security #____________________________ Birth Date _____/_____/_____
Phone (home): ______________________Work: _____________________ Ext:______ Cell: ____________________
Address: ____City:_________________State:_______ Zip___________

Patient Employment Information

Subscriber's Employer Name _______________________________Phone Number: __________________________
Address: _____________________________________City: _________________State: _________Zip:_________

INSURANCE INFORMATION

Primary Insurance Information

Name of subscriber: _________________________________ is insured a patient? Yes No
Subscriber Birth Date: _____/_____/_____ SSN ____________________
Subscriber's Employer Name _______________________________Phone Number: __________________________
Address: _____________________________________City: _________________State: _________Zip:_________
Insurance Company: ____________________________ Phone_____________________Group #: _______________
Address: _____________________________________City: _________________State: _________Zip: ________

Secondary Insurance Information

Name of subscriber: _________________________________ is insured a patient? Yes No
Subscriber Birth Date: _____/_____/_____ SSN ____________________
Subscriber's Employer Name _______________________________Phone Number: __________________________
Address: _____________________________________City: _________________State: _________Zip:_________
Insurance Company: ____________________________ Phone_____________________Group #: _______________
Address: _____________________________________City: _________________State: _________Zip: ________

I hereby authorize payment of the dental benefits otherwise payable to me, directly to Dr. Kindt, D.D.S.

____ ________________________
Signature (Employee/subscriber) Date

Consent For Services

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I will not hold Dr. Kindt or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this medical history form.

I give my consent for dental treatment that the doctor indicates on the examination chart and any other dental treatment deemed necessary or advisable as a corollary to the planned dental treatment. I have been advised of all probable complications of the dental treatment.

If patient is a minor, I hereby grant permission for dental treatment to be performed on this minor and will assume all responsibilities connected with such treatment.

I understand that I am financially responsible for dental fees, with or without insurance payment.

I hereby authorize any insurance company to release all information with bearing on the benefits payable under this or any other plan providing benefits or services.

______________________________________ ___________ _____________________________________
Signature of Patient (or Parent if minor) Date Dr. Kindt Signature