Medical History Form

Date _____/_______/________

Name _______________________ ____________________ ____________ Home Phone (____) _________________________
Last First Middle
Local Address ____Apt # ______________ 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 ___________________Emergency contact ________________________ Phone (____) ______________________
I authorize Dr. Kindt's office to contact and release information to my spouse/closest relative stated above.

Other Family Members Currently Patients? ____

Whom may we thank for referring you to our practice?
Name of person or office referring you to our practice: ____

____Dental Office _____Website ____Coworker ____ Insurance List Other _______________ ____________________

Health Information

Your answers are for our records only and will be considered confidential. Please note that during your exam you will be asked some questions about your responses and there may be additional questions concerning your health.

Have you ever been diagnosed or had any of the following?
Please check all that apply.

___ Aids+/HIV
___ Allergies Food/ Seasonal
____
___ Anemia
___ Arthritis
___ Artificial Joints
___ Asthma
___ Blood Disease
___ Blood Transfusion
___ Cancer ________________
___ Cardiovascular Disease
___ Diabetes Type _________
___ Difficulty Breathing
___ Dizziness
___ Drug/alcohol Abuse
___ Epilepsy/Seizures
___ Excessive Bleed/Blood Thinners

___ Fainting
___ Glaucoma
___ Hay Fever
___ Head Injuries
___ Heart Murmur
___ Hepatitis Type: ___________
___ High Blood Pressure
___ Hyper/Hypo Thyroid **(Circle 1)**
___ Jaundice
___ Kidney Disease
___ Liver Disease
___ Low Blood Pressure
___ Mental Disorders
___ Mitral Valve Prolapse
___ Nervous Disorders
___ Pacemaker
___ Pregnant– Due Date _________

___ Respiratory Problems
___ Rheumatic Fever
___ Rheumatism
___ Sinus Problems
___ Smoking/ Tobacco
___ STD
___ Stomach Problems
___ Stroke
___ Tuberculosis
___ Tumors
___ Ulcers

Are you allergic to:
Codeine Aspirin
Local Anesthetics Iodine
Sulfa Drugs Penicillin
Other ____________________
____

Do you have any disease, condition, or problem not listed above I should know about? Yes No
Please explain: ____
_

Do you require any pre-medications prior to dental treatment? Yes No
Are you wearing removable dental appliances? Yes No

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

Have you been under the care of a physician in the last 6 months? Yes No
If yes please explain: ____
Physician's name and number ____

Have you been admitted to a hospital or needed emergency care during the past five years? Yes No
Please explain:____

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:_________

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 ore services.

Signature of Patient or Parent if minor ____________________________________ Date ______/_______/______

Dr. Kindt Signature ____