

Adkins

Family
Cosmetic

Dentistry

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone or Pager: _____

Address: _____
Street Apartment # E-MAIL ADDRESS

City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

MEDICAL HISTORY

- Allergies _____
- Anemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer
- Chemotherapy
- Diabetes
- Dizziness / Fainting
- Epilepsy
- Excessive Bleeding
- Glaucoma
- Growths / Tumors
- Hay Fever
- Head Injuries
- Heart Attack
- Heart Disease
- Heart Murmur / MVP
- Hepatitis / Jaundice
- High Blood Pressure
- HIV
- Kidney Disease
- Latex Allergy
- Liver Disease
- Mental Health Issues
- Pacemaker
- Pain in Jaw Joints
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Stomach Problems
- Stroke
- Thyroid Problems
- Ulcers
- Venereal Disease

DRUG ALLERGIES

- Codeine Allergy
- Penicillin Allergy
- Other _____

WOMEN

- Are you pregnant?
Due Date: _____
- Are you nursing?
- Are you taking birth control?

Dental History

- Bite/ Chew Nails
- Biteguard Therapy
- Bleeding Gums
- Bleaching Treatment
- Blisters/ Sores on Lips
- Burning sensation on tongue
- Chew on one side of mouth

- Cigarette, pipe, or cigar smoking
 - Clench/ Grind Teeth
 - Gums swollen or tender
 - Jaw Pain or tiredness
 - Loose teeth or broken fillings
 - Mouth Breathing
 - Mouth pain, brushing
 - Orthodontic treatment
 - Pain around ear
 - Periodontal treatment
 - Sensitivity to cold, heat or sweets
 - Wisdom teeth removed
- How often do you floss?

- How often do you brush?

• Do you take antibiotics for dental appointments? _____ If so what antibiotic do you take: _____

• Are you taking Coumadin or other blood thinners? Yes No

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

• Are you now under the care of a physician? Yes No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____
 Prescribed Medications and over the counter medications: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

2704 Old Rosebud Rd, Ste # 210

Lexington, KY 40509

859-543-0333

Fax : 859-543-0774

Responsible Party Information

Name: _____
 Male Female Married Single Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone or Pager: _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____ E-MAIL ADDRESS _____
Responsible Party
Employer Name: _____ Occupation: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____ Phone _____

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Other _____
Insurance Plan Name and Address: _____

Secondary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Other _____
Insurance Plan Name and Address _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
Name of person or office referring you to our practice: «RefBy Name»

Consent for Services

I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If there is any change in my medical status, I will inform the dentist. I understand that this information will be used by my dentist to help determine appropriate and healthful dental treatment. I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me during the period of such care to third party payers and/ or other health practitioners.

Date: _____ Relationship to Patient: _____

Signature of patient, or guardian