RICHARD C. KENNEDY, JR., D.D.S.
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ACCOUNT INFORMATION

Name ______________________________ Date ______________

Preferred Name ______________________________ ☐ Male ☐ Female

Title (please circle one): Dr. Mr. Mrs. Ms. Miss

Birthdate ______________ Age ________

Address ______________________________

City ______________ State ______________ Zip ________

Email ______________________________

Home ( ) ______________ Work ( ) ______________

Mobile ( ) ______________ Other ( ) ______________

Whom may we thank for referring you? ______________________________

Employer ______________ Occupation ______________

In case of emergency, contact ______________________________

Phone Number ( ) ______________ Relationship to Patient ______________

ACCOUNT INFORMATION – Person Responsible For Account ☐ check if same as above

Name ______________________________ Date ______________

Relationship to Patient ______________________________

Home ( ) ______________ Work ( ) ______________

Mobile ( ) ______________ Other ( ) ______________

Email Address ______________________________

Billing Address ______________________________

City ______________ State ______________ Zip ________

PRIMARY INSURANCE INFORMATION ☐ check if no dental insurance

Insurance Company Name ______________________________

Insurance Address ______________________________

City ______________ State ______________ Zip ________

Insurance Company Phone ( ) ______________ Group ______________

Insured's Name ______________ Relationship to Patient ______________

Insured's Birthdate ______________ Insured's ID# ______________

Insured's Employer ______________________________

Insured's Phone ( ) ______________

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Company Name ______________________________

Insurance Address ______________________________

City ______________________________ State ______________ Zip ____________

Insurance Company Phone (   ) ______________________ Group# ______________________

Insured's Name ______________________________ Relationship to Patient ______________________

Insured's Birthdate ______________________________ Insured's ID# ______________________

Insured's Employer ______________________________

Insured's Phone (   ) ______________________

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I understand that the office will assist me in submitting the appropriate insurance forms. However, discrepancy in payment between my insurance carrier and the charges incurred are my responsibility.

Patient (or Guardian) Signature ______________________________ Date ______________

Office Use: ☐ Notice of Privacy Practices ☐ Dental Board of CA's Dental Materials Fact Sheet. Patient Initials ______

MEDICAL INFORMATION

Physician ______________________________ Phone (   ) ______________________

Address ______________________________ State ______________ Zip ____________

Are you under the care of a physician? ______________ Last Visit Date ______________

Please explain ______________________________

____

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Are you taking any prescription or over-the-counter or herbal supplement medications? ☐ Yes ☐ No

Please List ______________________________

____

Do you have, or have you had any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Mental Health Problems	☐	☐	Epilepsy, seizures	☐	☐	Heart Disease, Attack, Angina
☐	☐	Stroke	☐	☐	Alcohol / Drug Abuse	☐	☐	Glaucoma	☐	☐	Heart Surgery/Valve
☐	☐	Difficulty Breathing	☐	☐	Diabetes	☐	☐	Cold Sores/ Canker Sores	☐	☐	Congenital Heart Defect
☐	☐	High Blood Pressure	☐	☐	Abnormal Bleeding	☐	☐	Anorexia Nervosa / Bulimia	☐	☐	Mitral Valve Prolapse
☐	☐	Emphysema	☐	☐	Blood Transfusion	☐	☐	Arthritis	☐	☐	Pacemaker
☐	☐	Asthma	☐	☐	Hepatitis, Jaundice, Liver Disease	☐	☐	Venereal Disease, Herpes	☐	☐	Hospitalized for any reason
☐	☐	Hay Fever, Allergies	☐	☐	Kidney Problems	☐	☐	HIV+ / AIDS			
☐	☐	Sinus Problems	☐	☐	Cancer/Chemotherapy/ Radiation Treatment	☐	☐	Artificial Joints			
☐	☐	Tuberculosis (TB)				☐	☐	Head Injury			

Please list any other medical condition(s) that you have had: ______________________________

____

____

Name ____________________ Date ____________

For Women Only:

	Yes	No	
Are you taking birth control pills?	☐	☐	
Are you pregnant?	☐	☐	Week # ______
Are you nursing?	☐	☐	

Yes No
Are you allergic to any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Penicillin
☐	☐	Codeine	☐	☐	Jewelry/Metals	☐	☐	Tetracycline
☐	☐	Dental Anesthetics	☐	☐	Latex	☐	☐	Other

Please list any other drugs/materials that you are allergic to

____

____

DENTAL HISTORY

Name of former dentist ____________________ Phone ____________

Why have you come to the dentist today? ____________________

Has your doctor told you that you require antibiotics before dental treatment? ____________________

Are you currently in pain? ____________________

Have you ever had a serious/difficult experience associated with any previous dental work? ____________________

____

Yes No
Is there anything you would like to change about how your teeth look? ____________________

____

☐ ☐ Have you had any teeth extracted? ____________________

☐ ☐ Have you ever had orthodontic treatment? (braces?) ____________________

☐ ☐ Do your gums bleed while brushing? Or flossing? ____________________

☐ ☐ How many times a week do you floss? ____________________

☐ ☐ How many times a day do you brush? ____________________

☐ ☐ Do you avoid brushing any part of your mouth because of pain? ____________________

☐ ☐ Have you ever been told you have pyorrhea or periodontitis or gum disease? ____________________

☐ ☐ Do you have any growths or swelling in your mouth? ____________________

☐ ☐ Have you ever had a bad reaction to a dental anesthetic? When? ____________________

☐ ☐ Does food catch between your teeth? ____________________

☐ ☐ Do you gag easily? ____________________

☐ ☐ Do you ever awaken with an awareness of your teeth or jaws? How often? ____________________

☐ ☐ Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ____________________

☐ ☐ Have you ever been told you grind your teeth during sleep? How often? ____________________

continued on next page

Yes	No	
☐	☐	Do you have difficulty in opening your mouth widely? ______
☐	☐	Do you have tension headaches? How often? ______
☐	☐	Do you have an unpleasant taste or odor in your mouth? ______
☐	☐	Do you have any removable dentures, appliances, retainers, other? ______
☐	☐	Do you feel you will eventually wear full artificial dentures? ______

Please add anything you feel is important: ______

CONSENT

The information on this questionnaire is accurate to the best of my knowledge. This will be used by Dr. Kennedy and his staff to determine appropriate dental treatment. If there is any change in my medical status, I will inform Dr. Kennedy and his staff. If deemed advisable, I grant permission for my physician to be contacted for details and advice.

I authorize Dr. Kennedy or qualified associates to examine, x-ray, make study models, photograph, administer local anesthesia, sedation by inhalation, prescribe medications, or other diagnostic aids necessary to make a thorough diagnosis for my dental health.

Name ______ Date ______

☐ Adult Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian

NOTES