Kirkwood Dental
ASSOCIATES, PA.
WHERE SMILES NEVER END!

Patient Information & Medical History

To assist us in serving you, please complete the following form. The information provided is important to your professional dental health. If there have been any changes in your health, please let us know. If you have any questions, please feel free to ask us, we will be happy to help you complete it.

Today's Date_____ ☐ Male ☐ Female
Legal name _____ Age ____
Preferred Name _____
Date of Birth _____ SSN# _____
Address _____
_____
City _____ State _____ Zip _____
Billing Address (if different) _____
_____
City _____ State _____ Zip _____
☐ Single ☐ Married ☐ Divorced ☐ Widowed
Home Phone _____
Cell Phone _____
Email _____
Employer _____
Spouse/Partner's name _____
Spouse/Partner's phone _____
Emergency contact name & phone _____
_____

Appointment Confirmation method
(Please circle one):
Phone call Text message Email

Primary Dental Insurance
Insurance Co. Name _____
Group# _____ Subscriber ID _____
Subscriber's Name _____
Relationship _____ Employer _____
Date of Birth _____ SSN# _____

Secondary Dental Insurance (if applicable)
Insurance Co. Name _____
Group# _____ Subscriber ID _____
Subscriber's Name _____
Relationship _____ Employer _____
Date of Birth _____ SSN# _____

How would you like to receive your bills?
(Please circle one) Email or Mail

Pharmacy name _____
Address _____
_____
Phone _____
Physician & number _____
Cardiologist & number _____

The section below on PAGE ONE is for NEW patients ONLY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatments?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty chewing your food?	☐	☐
How often do you brush? _____		
How often do you floss? _____		
Do you avoid brushing any part of your mouth because of pain?	☐	☐

Do your gums: ☐ Bleed easily ☐ Bleed when you brush ☐ Bleed when you floss
☐ Feel swollen or tender
Are your teeth sensitive? ☐ Hot ☐ Cold ☐ Sweets

The section below on PAGE ONE is for NEW patients ONLY

Referred to us by _____
Previous Dentist & Number _____
_____ **Date of last visit** _____

	Yes	No
Have you ever noticed slow healing sore in or around your mouth?	☐	☐
Do you wear dentures?	☐	☐
Do you take fluoride supplements?	☐	☐
Have you had trauma in the jaw?	☐	☐
Do you clench or grind your teeth frequently?	☐	☐
Does it hurt when you chew?	☐	☐
Do you have sore jaw muscles or headaches upon awakening in the morning?	☐	☐
Have you ever been diagnosed with TMD temporomandibular (jaw) disorder?	☐	☐
Do you have pain in the face, cheeks, jaw, joints, throat, or temples?	☐	☐

Name _____

Date of Birth _____

	Yes	No
Have you ever been treated for low bone density or osteoporosis?	☐	☐
Are you taking blood thinners?	☐	☐
Do you require antibiotic premedication?	☐	☐

Are you **allergic**, or have you reacted adversely to any of the following?

Local anesthetics ("Novocaine")	☐	☐
Penicillin or Amoxicillin	☐	☐
Sulfa Drugs	☐	☐
Barbiturates, sedative, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex	☐	☐
Foods such as Bananas or Peanuts	☐	☐

Other _____

Other (please check all that apply)	Yes	No
Epilepsy, Seizures, or fainting Spells	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid Problems	☐	☐
Persistent cough or swollen glands	☐	☐
Cancer ☐ Chemotherapy ☐ Radiation	☐	☐
Diabetes	☐	☐
Tuberculosis	☐	☐
Respiratory diseases	☐	☐
Hepatitis, jaundice, or liver trouble	☐	☐
Sexually transmitted disease	☐	☐
HIV Positive/AIDS	☐	☐
Glaucoma	☐	☐

Please check if you: ☐ Drink Alcohol ☐ Smoke ☐ Have a history of substance abuse

Please check if you are: ☐ Taking birth control or other hormones ☐ Pregnant (expecting due date _____) ☐ Nursing

ONLY CHECK BELOW IF YES

Heart problems ☐ Chest Pain ☐ Shortness of Breath ☐ Heart Murmur ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Heart Valve Problem ☐ Taking Heart Medication ☐ Rheumatic Fever ☐ Pacemaker ☐ Artificial Valve

Blood Problems ☐ Abnormal Bleeding ☐ Anemia ☐ Hemophilia ☐ Easy Bruising ☐ Transfusions ☐ Frequent Nosebleeds

Allergy Problems ☐ Hay Fever ☐ Sinus Problems ☐ Skin Rashes ☐ Taking Allergy Medication ☐ Asthma

Bone or Joint Problems ☐ Arthritis ☐ Back or Neck Pain ☐ Joint Replacement (i.e. total hip, pins, or implants) ☐ Osteoporosis

Do you have any other disease, condition, or disability not listed? _____

_____

_____

Please list any surgeries and approximate date. _____

_____

_____

Please list any prescriptions medications or over the counter drugs you may take, and the condition it is taken for.

_____

_____

_____

_____

I have read all the information and have completed the above information. I certify that this information is true and correct to the best of knowledge. I will notify you of any changes in my health status or any of the above information. I hereby authorize the release of information relating to my insurance claims and give my permission for my physician to be contacted if necessary. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

Patient Signature (or Guardian of Minor) _____ Date _____