



Patient Information

Name: _____ Soc, Sec# _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Phone _____

Sex M F Age _____ Birthdate _____ Single Married Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Phone _____

Primary Insurance

Person Responsible for the Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec# _____

Address if different from the patient _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract# _____ Group# _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address if different from the patient _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract# _____ Group# _____ Subscriber # _____

Name of other dependents under this plan _____

Kenneth E. Henley, DDS

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These are things that are important to me about my Dental Health

CIRCLE ONE

My mouth is

- A) very comfortable
- B) moderately comfortable
- C) uncomfortable

I

A) think the appearance of my mouth is excellent

I am

- B) satisfied with the appearance of my mouth
- C) dissatisfied

I

- A) will do anything to keep my natural teeth
- B) want to keep my teeth, but have a certain budget of time and money I am willing to spend on them
- C) don't care whether I keep my teeth or not

I

- A) have a goal set for my oral health with a previous dentist
- B) want to set up goals concerning my dental health
- C) never set goal concerning my dental health

I

- A) have always done the best that was recommended for my dental health
- B) have not done what dentist have recommended for my mouth
- C) rarely go, and don't care much about having my dental work completed

I have

- A) put dentistry for myself and my family high on my priority list
- B) put dentistry for myself and my family low on my priority list
- C) it's on my list but hard to find

I think my present dental health is

- A) excellent
- B) good
- C) poor

I aspire to a mouth with:

- A) excellent health
- B) good health
- C) poor health

What are some questions about dentistry and oral health that you have never had adequately answered for you?

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Medical History

Patient Name _____

Although dental personal primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now Yes No N/A _____

Have you ever been hospitalized or had a major operation? Yes No N/A _____

Have you ever had a serious head or neck injury Yes No N/A _____

Are you taking any medications, pills, or drugs? Yes No N/A _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No N/A _____

Are you on a special diet? Yes No N/A _____

Do you use tobacco? Yes No N/A _____

Do you use controlled substance? Yes No N/A _____

Women: Are you Pregnant / Trying to get pregnant? Nursing?
 Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other _____

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

<input type="checkbox"/> AIDS/ HIV Positive
<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> Anaphylaxis
<input type="checkbox"/> Anemia
<input type="checkbox"/> Angina
<input type="checkbox"/> Arthritis/ Gout
<input type="checkbox"/> Artificial Heart Value
<input type="checkbox"/> Artificial Joint
<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Blood Transfusion

<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> Hepatitis B or C
<input type="checkbox"/> Herpes <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Hives or Rash
<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Leukemia
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Low Blood Pressure

<input type="checkbox"/> Breathing Problems <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Cold Sores/ Fever Blisters <input type="checkbox"/> Congenital Heart Disorder <input type="checkbox"/> Convulsions <input type="checkbox"/> Cortisone Medicine <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Easily Winded <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy or Seizures <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Fainting Spells/ Dizziness <input type="checkbox"/> Frequent Cough <input type="checkbox"/> Frequent Diarrhea <input type="checkbox"/> Frequent Headache <input type="checkbox"/> Genital Herpes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hay Fever <input type="checkbox"/> Heart Attack/ Failure <input type="checkbox"/> Heart Murmur* <input type="checkbox"/> Heart Pace Maker* <input type="checkbox"/> Heart Trouble/ Disease	<input type="checkbox"/> Lung Disease <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Pain in Jaw Joints <input type="checkbox"/> Parathyroid Disease <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Recent Weight Loss <input type="checkbox"/> Renal Dialysis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Rheumatism <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Shingles <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Stomach/ Intestinal Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Swelling of Limbs <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors or Growths <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Yellow Jaundice
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Have you ever had any serious illness not listed above? Yes No NA_____

Comments_____

*Condition may require medication. N/A not answered by patient

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN

DATE

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