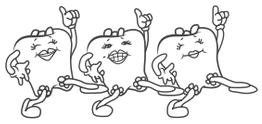

KERRY FAMILY DENTAL

3250 Plymouth Rd, Suite 104
Ann Arbor, MI 48105
kerryperio@gmail.com
734-995-0515

Patient Full Name Mr/Ms/Mrs. _____ Cell Phone# _____ Home Phone# _____ Work Phone# _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Birthdate _____ Marital Status _____ Spouse's Name _____

GENERAL INSURANCE INFORMATION

Name of Primary Dental Insurance Company _____ Group # _____

Policyholder's Name _____ ID or SS# _____ Birthdate _____

Policyholder's Employer _____ Years with firm _____

Your relationship to policyholder _____ Have you used this dental insurance Select one ☐ Yes ☐ No

Name of Secondary Dental Insurance Company _____ Group # _____

Policyholder's Name _____ ID or SS# _____ Birthdate _____

Policyholder's Employer _____ Years with firm _____

Your relationship to policyholder _____ Have you used this dental insurance Select one ☐ Yes ☐ No

Family Dentist _____ Office Phone # _____

Family Physician _____ Office Phone # _____

Person financially responsible _____ Relationship to you _____

Billing address: Street _____ City _____ State _____ Zip _____

Whom should we notify in case of an emergency: Name _____ Phone _____

Whom may we thank for this referral _____

MEDICAL & DENTAL INFORMATION

(Answers to the following questions are for our records and will be considered confidential)

Select one

Yes No

____ ____ **1.** Are you or have you recently been experiencing pain in your mouth or face?

____ ____ **2.** Do you have any dental condition which you believe requires immediate attention today?

____ ____ **3.** Do you consider your general health to be good? Approximate date of last physical examination?

____ ____ **4.** Are you being treated for any condition by a physician now? What?

____ ____ **5.** Are you now taking any medications (drugs or pills)? *Please bring a list of all your medications from your health care provider to your initial appointment.*

____ ____ **6.** Are you allergic or have you reacted adversely to any of the following?

___ Local anesthetic (novocaine)
___ Penicillin or any other antibiotics
___ Aspirin
___ Barbiturates (sleeping pills)
___ Codeine
___ Iodine
___ Nonsteroidal anti-inflammatory (Advil/Ibuprofen)
___ Other

____ ____ **7.** Have you ever had a serious illness or operation?

____ ____ **8.** Have you ever had an extremely frightening experience with dentistry? If so, please explain

Please check any of the following that you have experienced.

___ Injury to face or jaws
___ High blood pressure ___ Low blood pressure
___ Blood transfusion
___ Bleeding problems
___ HIV exposure (AIDS)
___ Prosthetic joint replacement
___ Any organ transplants
___ Rheumatic fever
___ Heart murmur
___ Heart attack or disease
___ Angina
___ Mitral valve prolapse
___ Stroke
___ Congenital heart lesions
___ Bacterial endocarditis
___ Diabetes (sugar disease)
___ Kidney or bladder trouble
___ Hepatitis or liver trouble
If yes, check the following
___ Hepatitis A infectious
___ Hepatitis B serum
___ Hepatitis C
___ Jaundice
___ Tuberculosis
___ Venereal disease
___ Lung trouble
___ Irradiation or chemotherapy
___ Asthma
___ Hay fever
___ Blood disorder
___ Psychiatric treatment
___ Frequent severe headaches
___ Cortisone, hydrocortisone, or prednisone
___ Frequent canker or cold sores
___ Tendency to bruise easily
___ Tendency to faint
___ Persistent cough
___ Glaucoma

Select one

Yes No

9. When was the first time you were seen by your general dentist?

10. How frequently do you visit your dentist?

11. When did you last have your teeth cleaned?

____ ____ **12.** Has anyone ever mentioned that you have periodontal disease?

____ ____ **13.** Have you ever had periodontal (gum) treatment? When?

____ ____ **14.** Have you ever had any teeth extracted? Why?

Any associated bleeding or healing problems?

____ ____ **15.** Have you ever had orthodontic treatment?

____ ____ **16.** Have you ever had endodontic (root canal) treatment?

____ ____ **17.** Do you have any removable bridges? How long have you had them?

____ ____ Are they comfortable?

____ ____ **18.** Would you be greatly disturbed if you had to lose all your natural teeth?

____ ____ **19.** Did either of your parents lose all of their natural teeth?

____ ____ **20.** Are you dissatisfied with the appearance of your teeth? Why?

____ ____ **21.** Do you have any missing teeth that have not been replaced? Why?

____ ____ **22.** Are there any foods which you cannot chew? Which?

____ ____ **23.** Have you noticed any loose teeth? Where?

____ ____ **24.** Have any of your teeth recently separated creating spaces between them and/or allowing food to wedge between them? Where?

25. Are your teeth sensitive to: _____ cold, _____ hot, or _____ sweets?

Select one

Yes No

____ ____ **26.** Do your gums ever bleed? When?

____ ____ **27.** Have you noticed any bad tastes or odors from your mouth?

28. You brush your teeth _____ times per day.

What type of toothbrush do you use?

____ hard ____ medium ____ soft

____ ____ Do you use any of the following?

____ dental floss ____rubber tip ____ Stimudents

other

____ ____ **29.** Have you ever had oral hygiene instruction?

____ ____ **30.** Do you smoke cigarettes or use smokeless tobacco? Which? How often and how long?

____ ____ **31.** Is it difficult to open your mouth as wide as you would like?

____ ____ **32.** Do you ever have pain in the region in front of your ears?

____ ____ **33.** Do you clench, grit or grind your teeth in the daytime or while you are sleeping?

____ ____ **34.** Do you have any habits, such as biting your nails, chewing on a pipe or pencil, etc?

____ ____ **35.** Have you been under more than average nervous tension lately?

____ ____ **36.** Do you breathe through your mouth much of the time?

____ ____ **37.** Is there any health information which wasn't asked, which you feel may influence your dental treatment?

____ ____ **38.** Are you wearing contact lenses?

WOMEN ONLY:

____ ____ Are you pregnant?

____ ____ Are you taking birth control pills?

____ ____ Have you undergone or are you undergoing menopause?

I certify that I have read and understand the above. I will not hold my dentist, or any other member of his or her staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient's Signature _____ Date _____

CONSENT & RESPONSIBILITY

I hereby authorize and request the performance of dental services for myself or for: _____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his or her supervised staff for diagnostic purposes or dental treatment.

I understand and acknowledge that I am ultimately financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

I hereby authorize Dr(s). _____ to release information about my diagnosis and treatment plan to my general dentist, physician and insurance company if necessary.

Patient's Signature _____ Date _____

Guardian's Signature (if patient is under 18) _____ Date _____

Please bring the completed/printed form to your first appointment or email digitally filled out form to **kerryperio@gmail.com** at least 24 hours prior to your appointment.