



Keene Family Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date: _____ Home Phone (____) _____ Cell Phone (____) _____
 Name: _____ SS#: _____
 Address: _____ E-mail: _____
 City: _____ State: _____ Zip: _____
 Sex: M F Age: _____ Birthdate: _____
 Married Widowed Single Minor Separated Divorced
 Whom may we thank for referring you? _____
 In case of emergency, who should be notified? _____

Primary Insurance

Person Responsible for Account: _____
 Relation to Patient: _____ Birthdate: _____ SS#: _____
 Address (if different from patient's): _____
 Phone: (____) _____ City: _____ State: _____ Zip: _____
 Person Responsible Employed by: _____ Occupation: _____
 Business Address: _____ Business Phone: (____) _____
 Insurance Company: _____ Dental/Member Services Number: _____
 Subscriber #: _____ Group #: _____
 Names of other dependents under this plan: _____

Dental History

Reason for Today's Visit: _____ Date of Last Dental Care: _____
 Former Dentist: _____ Date of Last Dental X-rays: _____
 Address: _____
 Check (✓) if you have had any of the following: Bad breath Grinding
 Sensitivity to heat Bleeding Gum Loose teeth or broken fillings
 Sensitivity to sweets Clicking or Popping Periodontal treatment
 Sensitivity when biting Food collection between teeth Sensitivity to cold
 Sores or growth in your mouth
 How often do you floss? _____ How often do you brush? _____



Medical History

Physician's name: _____ Date of last visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you had any serious illnesses or operations? Yes No

If yes, describe: _____

Have you ever had a blood transfusion? Yes No

If yes, give approximate date: _____

(WOMEN) Are you pregnant? Yes No Nursing? Yes No

Taking birth control pills? Yes No

Please circle if you have or have had any of the following:

- | | | | |
|-------------------------|---------------------|-----------------------|-------------------------|
| Anemia | Cortisone Treatment | Hepatitis | Scarlet Fever |
| Arthritis, Rheumatism | Cough, Persistent | High Blood Pressure | Shortness of breath |
| Artificial Heart Valves | Cough up blood | HIV/AIDS | Skin Rash |
| Artificial Joints | Diabetes | Jaw Pain | Stroke |
| Asthma | Epilepsy | Kidney disease | Swelling of feet/ankles |
| Back problems | Fainting | Liver disease | Thyroid problems |
| Blood disease | Glaucoma | Mitral Valve prolapse | Tobacco habit |
| Cancer | Headaches | Pacemaker | Tonsillitis |
| Chemical Dependency | Heart Murmur | Radiation Treatment | Tuberculosis |
| Chemotherapy | Heart Problems | Respiratory disease | Ulcer |
| Circulatory Problems | Hemophilia | Rheumatic fever | Venereal disease |

Other: _____

What medications are you taking? _____

What medications are you allergic to? _____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign direction to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I certify that the information above is correct and complete.

Signature of patient, guardian or personal representative

Date

Please print name of patient, parent, guardian or personal representative.

Relationship to patient