KIMBERTON DENTAL ASSOCIATES – Patient Questionaire

Dr. Nhat-Khai Do – Dr. Darry Ma

I. Patient Information:

Patient Name: _____ SS#: _____ DOB: _____

Male☐ Female☐ Other☐ Single☐ Married☐ Divorced☐ Child☐

Address: _____

Phone #: Home: _____ Work: _____ (ext _____) Cell: _____

Date of last dental visit: _____ Reason for today's visit: _____

Do you have Dental Insurance: _____ Name of your insurance company: _____

Employer_____ Employer's address_____

II. Medical History:

1. Have you ever had any of the followings – check those that apply:

☐ AIDS	☐ Liver Disease	☐ Ulcers	☐ Excessive Bleeding	☐ Epilepsy
☐ Head Injury	☐ Hepatitis	☐ Stomach Problems	☐ Mitral Valve Prolapse	☐ Kidney Disease
☐ Fainting	☐ Nervous Disorder	☐ Sinus Problems	☐ Artificial Joints	☐ Stroke
☐ Anemia	☐ Mental Disorder	☐ Asthma	☐ Rheumatic Fever	☐ Heart Disease
☐ Arthritis	☐ Tumors	☐ T.B.	☐ Heart Murmur	
☐ Glaucoma	☐ Cancer	☐ Diabetes	☐ Respiratory Disorder	
☐ Hay Fever	☐ Radiation therapy	☐ High Blood Press.	☐ Pacemaker	

List of Medications:_____

_____

Drug Allergies: _____

2. Have you ever had complications from dental treatment? ☐

If Yes, please explain: _____

3. Have you been admitted to a hospital during the past **two years** or have other health problems that need further explanation? If Yes, please explain: _____

4. Who is your primary care physician? Name of your physician: _____ Phone #: _____

III. Dental History

1. Have you ever smoked or chewed tobacco: _____
2. How often do you brush your teeth: _____ How often do you floss: _____
3. Do your gums bleed: _____
4. Are you pleased with your teeth color? ____ Position of your teeth? ____ Shape of your teeth? ___
5. Do you have difficulty with chewing? ___ Do you have clicking in your jaw or TMJ discomfort ____
6. Is there anything else about your mouth that you would like to be improved? _____
7. Whom may we thank for referring you to our practice? _____

Friend☐ Co-worker☐ Relative☐ Phonebook☐ Website☐ Facebook☐ Other☐

To the best of my knowledge, all information listed above is correct. I acknowledge that I have received a Notice of Privacy Practices. If I have any future changes, I agree to inform the providing Doctor.

Signature _____

IV. Consent for Services

I understand that I am responsible for all fees at time of services. I understand that my insurance is a contract between myself and the company, and that I am responsible for all debt. Kimberton Dental Associates will bill them directly, as a courtesy to me. All emergency treatment must be paid at time of services, no credit will be extended. I am aware that a finance fee of 18% will be charged to my account for all balances over 90 days. I accept any pre-treatment estimates for a period of no more than 60 days. I grant my permission to Kimberton Dental Associates to release my information to my insurance company. I am responsible for any and all collection fees, if applicable. I have read the above conditions and agree to this contract.

Signature _____ Date: _____