

KIMBERTON DENTAL ASSOCIATES – Patient Questionnaire

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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:

- | | | | | |
|--------------------------------------|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tumors | <input type="checkbox"/> T.B. | <input type="checkbox"/> Heart Murmur | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory Disorder | |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> High Blood Press. | <input type="checkbox"/> 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: _____