Our practice grows by referrals. Please let us know how you heard about us. _____

PATIENT INFORMATION

NAME _____ BIRTHDATE _____ PHONE # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SOC. SEC. # _____ DRIVERS LIC. # _____

EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

PLEASE CIRCLE: MINOR SINGLE MARRIED DIVORCED WIDOWED SEX M F

IF PATIENT IS FULLTIME STUDENT (OVER 19) NAME OF SCHOOL/COLLEGE _____

SPOUSE OR PARENT'S NAME _____ BIRTHDATE _____

CLOSEST RELATIVE NOT LIVING WITH YOU _____ RELATIONSHIP _____

PHONE _____ ADDRESS _____

RESPONSIBLE PARTY

(IF SAME AS ABOVE – GO TO NEXT SECTION)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

RELATIONSHIP TO PATIENT _____ HOME PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SOC. SEC. # _____ DRIVERS LIC. # _____

EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

PRIMARY NSURANCE INFORMATION

INSURED'S NAME _____

INSURED'S BIRTHDATE _____

INS. CO. NAME _____

INS. CO. ADDRESS _____

_____

POLICY # _____

INS. PHONE # _____

SECONDARY INSURANCE INFORMATION

INSURED'S NAME _____

INSURED'S BIRTHDATE _____

INS. CO. NAME _____

INS. CO. ADDRESS _____

_____

POLICY # _____

INS. PHONE # _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. TERMS ARE CASH PAYABLE AT TIME SERVICES ARE RENDERED. A 1% PER MONTH SERVICE CHARGE WILL BE APPLIED TO ALL BALANCES 60 DAYS OLD OR OLDER.

I ALSO UNDERSTAND THAT IF LEGAL PROCEEDINGS ARE INSTITUTED BY KENDALL POINTE DENTAL TO COLLECT ANY UNPAID AMOUNTS DUE FROM THE RESPONSIBLE PARTIES HEREIN, THEN KENDALL POINTE DENTAL WILL BE ENTITLED REASONABLE COSTS OF COLLECTION INCLUDING, WITHOUT LIMITATION, ATTORNEY FEES, COURT COSTS AND RELATED EXPENSES.

_____

Signature of Patient or Parent if Minor **Date**

PATIENT REGISTRATION

Kendall Pointe Dental – 1991 Wiesbrook Drive – Oswego, IL 60543 – (630) 801-4222

Name _____

PATIENT MEDICAL HISTORY

Physician _____ Phone # _____ Date of Last Visit _____

	YES	NO	
Do you have any current health problems?	☐	☐	If so for what? _____
Are you under a Physician's care now?	☐	☐	If so for what? _____
Are you currently taking any medication?	☐	☐	If so what? _____
Do you require Pre-Medication before dental treatment	☐	☐	If so what? _____

Please indicate which of the following applies to you. (Check only if you have or have had in the past)

☐ Heart Failure	☐ A.I.D.S.	☐ Bruise Easily	☐ Cosmetic Surgery
☐ Heart Attack	☐ A.R.C.	☐ Pigment Lesions in Mouth	☐ Venereal Disease
☐ Heart Disease	☐ Hepatitis A Hepatitis B	☐ Pneumocystitis	☐ Asthma
☐ Angia Pectoris	☐ Glaucoma	☐ Night Sweats, Fever	
☐ Heart Murmur	☐ Liver Disease	☐ Hay Fever/Allergies	
☐ High Blood Pressure	☐ Yellow Jaundice	☐ Sinus Trouble	
☐ Rheumatic Fever	☐ Blood Transfusion	☐ Arthritis	
☐ Sickle Cell	☐ Drug Addiction	☐ Diabetes	
☐ Scarlet Fever	☐ Hemophilia	☐ Thyroid Disease	
☐ Artificial Heart Valve	☐ Fever Blisters	☐ X-ray or Cobalt Treatment	
☐ Pacemaker	☐ Epilepsy/Convolutions	☐ Cortisone Medicine	
☐ Heart Surgery	☐ Fainting/Seizures	☐ Pain in Jaw Joints	
☐ Stroke	☐ Nervousness	☐ Unexplained Weight Loss	
☐ Kidney Trouble	☐ Cancer	☐ Emphysema	
☐ Ulcers	☐ Chemotherapy	☐ Tuberculosis	
☐ Anemia	☐ Rheumatism	☐ Psychiatric Tx	

Are you allergic or have you reacted adversely to any of the following? (Check only if the answer is YES)

☐ Aspirin	☐ Percodan	☐ Erythromycin	☐ Penicillin
☐ Darvon	☐ Local Anesthetic	☐ Valium	☐ Codeine
☐ Nitrous Oxide	☐ Other: _____		

PATIENT DENTAL HISTORY

How long has it been since you have seen a dentist? _____

Are you having problems now? _____

If so what problems are you having? _____

Please indicate which of the following applies to you. (Check only if answer is YES)

☐ Is your present dental health poor?	☐ Have you ever had a Periodontal (Gum) treatment?
☐ Are you apprehensive about dental treatment?	☐ Do you have problems with teeth or fillings breaking?
☐ Are your teeth sensitive to hot, cold, sweets, pressure?	☐ Do your gums bleed or feel tender or irritated?
☐ Are you unhappy with the appearance of your teeth?	☐ Do you have loose, chipped or shifting teeth?
☐ Do you have headaches, earaches or neck pains?	☐ Do you regularly use Dental Floss?
☐ Do you wear Dentures? (Partials or Full) Year Made _____	
☐ Are you unhappy with your dentures?	☐ Have you ever worn braces on your teeth?
☐ Would you like to know more about permanent replacements?	☐ Have you ever had a bad dental experience in the past?

Signature of Patient or Parent if Minor

HEALTH HISTORY

Date