Kellerman Dental

Today's Date: Patient's Name: Last First

Home Phone Cell Phone Work Phone

E-mail Address:

Address: City: State: Zip Code:

Date of Birth: *Age: Sex: M F Social Security Number: Marital Status: Please Circle Single, Married, Partner, Separated, Widowed

Emergency Contact: Relationship: Contact Number:

Reason for this Visit: How did you hear about our office? (please list a referring friend by name)

Please list the names of any immediate family members who have been seen at our office:

If a patient is a minor (under 18), they need to be accompanied to all visits by parent/guardian or a designated adult. Failure to follow this will prevent the minor from being seen for their appointment.

Responsible Party Name (If under 18 Parent or Guardian Name) Or Circle: Same as Above

Last: First: Relationship to Patient:

Date of Birth: Home Phone: Alternate Phone:

Social Security Number: Employer:

Do you have a primary dental insurance? Y N Name of Insurance:

Do you have a secondary dental insurance? Y N Name of Insurance:

Dental History

What is the name of your last dentist?

How long since your last visit to a dentist?

Have you had periodontal (gum) treatments? Y N

Do you currently have dentures (partial or full)? Y N

---if yes, Please describe the fit of your existing denture(s)?

Please check all treatment you're interested in:

- ☐ Braces
- ☐ Bridges/Crowns
- ☐ Cosmetic Dentistry
- ☐ Dental Implants
- ☐ Healthy Gums
- ☐ Invisalign
- ☐ Replacing Missing Teeth
- ☐ Tooth Colored Fillings
- ☐ Veneers
- ☐ Whitening

Please list any other concerns or requests you would like to share with us.

Medical Information

Please CHECK each box YES or NO if you have had or are currently being treated for any of the conditions listed below.

PLEASE CHECK:	YES	NO	PLEASE CHECK:	YES	NO	PLEASE CHECK:	YES	NO
Aids	☐	☐	Excessive Bleeding	☐	☐	Pace maker	☐	☐
Allergies	☐	☐	Fainting	☐	☐	Phen Fen	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Pregnant Currently	☐	☐
Angina Pectoris	☐	☐	Hay Fever	☐	☐	Expected Due Date:		
Arthritis	☐	☐	Heart Disease/Attack	☐	☐	Psychiatric Treatment	☐	☐
Artificial Heart Valve	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐
Artificial Joints	☐	☐	Heart Surgery	☐	☐	Respiratory Problems	☐	☐
Asthma	☐	☐	Hepatitis A	☐	☐	Rheumatism	☐	☐
Blood Disease	☐	☐	Hepatitis B	☐	☐	Scarlet Fever	☐	☐
Bruise Easily	☐	☐	Hepatitis C	☐	☐	Sinus Problems	☐	☐
Cancer	☐	☐	High Blood Pressure	☐	☐	Stomach Problems	☐	☐
Chemo Therapy	☐	☐	HIV Positive	☐	☐	Stroke	☐	☐
Congenital Heart Lesions	☐	☐	Jaundice	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Jaw Joint Pain	☐	☐	Tuberculosis	☐	☐
Dizziness	☐	☐	Kidney Disease	☐	☐	Ulcers	☐	☐
Drug Addiction	☐	☐	Low Blood Pressure	☐	☐	Venereal Disease	☐	☐
Emphysema	☐	☐	Mitro Valve Prolapse	☐	☐	Other: ***Please list:***	☐	☐
Epilepsy	☐	☐	Oral Piercings	☐	☐			
Does the patient have any physical, mental, learning or developmental disabilities?				☐	☐	***If yes, please list:***		
Any other special needs that we should be aware of to better help the patient?				☐	☐	***If yes, please list:***		

	Yes	No
Do you use tobacco? (smoking, snuff, chew)	☐	☐
Has a physician recommended that you take antibiotics (as a premedication) prior to your dental treatments?	☐	☐
Are you taking or scheduled to begin taking Fosamax or Actonel for Osteoporosis?	☐	☐
Do you have any disease, condition, or problem not listed above that you think we should know about?	☐	☐
--If yes, please list:		

ALLERGIES

	Yes	No	Other:
Aspirin	☐	☐	***Please list***
Codeine	☐	☐	
Darvocet	☐	☐	
Erythromycin	☐	☐	
Latex	☐	☐	
Penicillin	☐	☐	
Percocet	☐	☐	
Valium	☐	☐	
Vicodin	☐	☐	

MEDICATIONS *Please list all current medications*:	**PREMEDICATE**	
	Please CHECK if you have ever had any of the following:	**Yes No**
	Artificial Heart Valves	☐ ☐
	A history of infective endocarditis	☐ ☐
	Any serious congenital heart condition	☐ ☐
	Cardiac transplant that develops a problem in a heart valve	☐ ☐
	Any artificial item implanted into your body (in the last two years)	☐ ☐

Physician's Name: _____ Phone: _____

Preferred Pharmacy Name: _____ Phone: _____

THE UNDERSIGNED HEREBY AUTHORIZES KELLERMAN DENTAL, DR. KELLERMAN, AND TEAM TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DR. KELLERMAN TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS. I ALSO AUTHORIZE DR. KELLERMAN TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION AND THERAPY, THAT MAY BE INDICATED. I ALSO UNDERSTAND THE USE OF ANESTHETIC AGENTS EMBODIES CERTAIN RISK SUCH AS PROLONGED TEMPORARY OR PERMANENT NUMBNESS OR TINGLING. **WE RESERVE THE RIGHT TO REFUSE SERVICE AND OR CHARGE FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 48 HOURS ADVANCE NOTICE.** RESPONSIBILITY OF REPAYMENT OF DENTAL SERVICES PROVIDED IN THIS OFFICE FROM MYSELF OR MY DEPENDENTS IS MINE, **DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED**, UNLESS FINANCIAL ARRANGEMENTS HAVE BEEN MADE. IN THE EVENT ANY UNPAID BALANCE, INCLUDING PRINCIPAL INTEREST AND LATE FEES IS PLACED WITH A COLLECTION AGENCY, A FEE OF 50% OF THE UNPAID BALANCE SHALL BE ADDED TO THE UNPAID BALANCE DUE FOR PATIENT. PATIENT ALSO AGREES TO PAY ALL OTHER COSTS INCURRED BY KELLERMAN DENTAL FROM THE COLLECTION AGENCY, INCLUDING BUT NOT LIMITED TO, COURT COSTS, INTEREST AND LATE FEES.

Patient/ Guardian Signature **Date Signed**

This authorization will remain in effect for one year from the above date.