KIMBERLY DENTAL PATIENT INFORMATION

Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ How may we address you: _____

DOB:_____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____
Billing address (if different): _____City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Email: _____
Driver's license #: _____ State: _____ SSN: _____

Employer/Occupation: _____ Business Phone: _____

Spouse's name & phone #: _____ Emergency Contact: _____

Primary Dental insurance: _____ Group #: _____ SSN#: _____
Subscriber's name: _____ Subscriber ID: _____ DOB: _____
Secondary dental insurance: _____ Group #: _____ SSN# _____
Subscriber's name: _____ Subscriber ID: _____ DOB: _____

Name of previous dentist: _____ Date of last dental visit: _____

DENTAL HEALTH HISTORY

Are you apprehensive about dental treatment?	Yes	No	Do you prefer to save your teeth?	Yes	No
Have you had problems w/ previous dental care?	Yes	No	Do you clench or grind your teeth?	Yes	No
Do you gag easily?	Yes	No	Does your jaw click or pop?	Yes	No
Do you like the appearance of your teeth?	Yes	No	Does food catch between your teeth?	Yes	No
Are your teeth sensitive?	Yes	No	Difficulty chewing food?	Yes	No
Do you avoid brushing due to pain?	Yes	No	Do you chew on one side of your mouth?	Yes	No
Are any teeth loose, chipped, tipped, or shifted?	Yes	No	Do your gums bleed easily?	Yes	No
Have you had gum treatment or surgery?	Yes	No	Do your gums bleed when flossing?	Yes	No
Have you had permanent teeth removed?	Yes	No	Do your gums feel swollen or tender?	Yes	No
Do you use dental floss?	Yes	No	How often do you brush?		
Do you dislike dentistry?	Yes	No	Have you had an unpleasant experience? If so, explain:	Yes	No

Are your teeth sensitive to:

Hot Cold Sweets Pressure

What is your chief concern regarding your dental health? _____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use of my records (or my child's record) to carry out treatment, obtain payment, and for those activities and healthcare operations that are related to payment or treatment. I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental care insurance may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. I attest to the accuracy of the information on this page.

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____