

KENITH R. CRAIG II, D.D.S.

Patient Information

(This information is necessary for our files and will be considered confidential)

Today's Date _____

Patient's Name _____ Date of Birth _____ Age _____

___ Married ___ Single ___ Divorced ___ Separated ___ Widowed

___ Student/Name of School _____ City/State _____

If patient is a minor, parent or guardian's name _____

Home address _____ City _____ Zip _____

Home phone # _____ E-mail address _____

Cell phone # _____ Drivers license# _____ State ___ Social Security # _____

Patient/parent employed by _____ Occupation _____

Address _____ Business Phone# _____

Spouse's name _____ Date of Birth _____ Social Security # _____

Spouse employed by _____ Occupation _____

Business address _____ Business phone# _____

Name of nearest relative not living with you _____ Relationship _____

Address _____ Home phone # _____

Name of Physician _____ City _____ Phone # _____

Former Dentist _____ City/State _____ Phone # _____

Whom may we thank for referring you to our office _____

INSURANCE INFORMATION

Primary insured's name _____ Secondary insured's name _____

Insurance Co _____ Insurance Co _____

Group/Policy# _____ Group/Policy# _____

Employer _____ Employer _____

TERMS & CONDITIONS

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency services or dental services performed without financial arrangements must be paid for at the time of the visit. We will help prepare your insurance forms to assist in collection from your insurance and credit your account, however, this office cannot render services on the assumption that our charges will be paid by an insurance company. I grant you permission to telephone me at home or work to discuss matters related to this form. I have read and understand the above conditions.

Signature (Parent, if patient is a minor)

Date

HEALTH QUESTIONNAIRE

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you in good health? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you under the care of a physician?
If yes, what is the condition being treated? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any serious illness or operation?
If yes, what was the illness or operation? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized?
If yes, what was the reason? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you require antibiotic pre-medication for dental treatment? If Yes, which medication? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any disease or condition not listed that we should be aware of?
If yes, please explain _____ |

List Medications you are currently taking: _____ _____ _____ _____	Allergies or sensitivities to: <input type="checkbox"/> Aspirin <input type="checkbox"/> Barbiturates(Sleeping Pills) <input type="checkbox"/> Penicillin <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Codeine <input type="checkbox"/> Tetracycline <input type="checkbox"/> Iodine <input type="checkbox"/> Sulfa <input type="checkbox"/> Latex <input type="checkbox"/> Other _____	Artificial Joints: <input type="checkbox"/> Hip When? _____ <input type="checkbox"/> Knee When? _____ <input type="checkbox"/> Other _____ When? _____
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Do you have, or have you had, any of the following: (Please check known conditions)

Cardiac Conditions: <input type="checkbox"/> Angina <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Congenital Heart Lesions <input type="checkbox"/> Heart Murmur When Diagnosed _____ <input type="checkbox"/> Heart Problems <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Pacemaker <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke	Diseases: <input type="checkbox"/> AIDS <input type="checkbox"/> Blood Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hepatitis Type _____ <input type="checkbox"/> Herpes	<input type="checkbox"/> HIV Positive <input type="checkbox"/> Jaundice <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Venereal Disease/ STD's	Other Conditions: <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis/ Rheumatism <input type="checkbox"/> Asthma <input type="checkbox"/> Back Problems <input type="checkbox"/> Bleeding abnormally with extraction, surgery <input type="checkbox"/> Cancer Type _____	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Cortisone Treatments <input type="checkbox"/> Cough, persistent or bloody <input type="checkbox"/> Fainting/Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Jaw Pain <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Nervous Problems <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Skin Rash <input type="checkbox"/> Special Diet <input type="checkbox"/> Swelling of Feet/Ankle <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tumor/Growth on Head/Neck <input type="checkbox"/> Ulcer <input type="checkbox"/> Weight Loss
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- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a tobacco habit? Present User ____ Former User _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever taken Fen-Phen or Redux? If Yes, When? _____ For how long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you on or have you ever taken oral bisphosphonate treatment such as Fosamax, Boniva or Actonel? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever taken Aredia or Zometa? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any unfavorable reaction from local anesthetic? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any serious trouble associated with previous dental treatment?
If yes, please explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an upsetting experience in the dental office?
If yes, please explain _____ |

How long has it been since your last dental treatment? _____ Last x-rays? _____
 How do you feel about your teeth? _____
 Are you satisfied with the appearance of your teeth? _____

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does food tend to get caught between your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your gums often bleed when you brush? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you experienced problems with your jaw? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you grind or clench your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have popping or soreness in your jaw? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have difficulty opening or closing your mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have difficulty with chewing? |

Have you ever had: Orthodontic treatment? _____ When? _____ Oral surgery? _____ When? _____
 Periodontal treatment? _____ When? _____ Worn a bite appliance? _____

FOR WOMEN ONLY: Are you pregnant? Yes, what month? _____ Are you nursing? Yes No
 Are you taking birth control pills? Yes No

I hereby certify that the above information is true and correct to best of my knowledge.

 Signature (Parent, if patient is a minor)

 Date