ALAN G. KLINE, D.D.S.
JOHN P. VELTMAN, D.D.S.
FAMILY DENTISTRY

Today's Date: ____/____/____
Birthdate: ____/____/____
Age: _____ ❑ Male ❑ Female
Social Security #: _____
Driver License #: _____

About You

Name: _____ Nickname: _____
Last First Mi Mr Mrs Ms Dr

E-mail Address: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone: (____)_____ Cell: (____)_____ Work Phone: (____)_____ Ext: ____

When is the best time to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street City State Zip

Emergency Contact: _____ Relation: _____ Work Phone: (___)_____ Ext: ___

Emergency Contact's Address: _____ Home Phone: (____)_____
Street City State Zip

Person Responsible for Account if other than Yourself

Name: _____ Relation: _____ Home Phone: (____)_____ Social Security #: _____

Employer: _____ Work Phone: (____)_____ Ext. ___ Drivers License #: _____

Billing Address: _____
Street City State Zip

Spouse Information

Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone: (____)_____ Ext. ___ Drivers License #: _____

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontal Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street City State Zip

Insured's Name: _____ Social Security #: _____ Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontal Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street City State Zip

Insured's Name: _____ Social Security #: _____ Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street City State Zip

CONTINUED ON BACK

Medical History

Personal Physician

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____

Phone #: (_____) _____ Date of Last Visit: _____

Physical Health

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician?

Please Explain: _____

Do you smoke or use any form of tobacco? ❑ Yes ❑ No

For Women:

Are you taking birth control pills? ❑ Yes ❑ No Are you pregnant? ❑ Unsure ❑ Yes ❑ No Week#: ____ Are you nursing? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Aspirin ❑ Codeine ❑ Erythromycin ❑ Latex ❑ Sedatives ❑ Tetracycline
❑ Barbiturates ❑ Dental Anesthetics ❑ Jewelry/Metals ❑ Penicillin ❑ Sulfa Drugs ❑ Other

Additional allergies? _____

Do you take any of the following?

❑ Acetaminophen ❑ Aspirin ❑ Cold Remedies ❑ Nitroglycerin ❑ Thyroid Medicine
❑ Antibiotics ❑ Blood Thinners ❑ Digitalis/Heart Medication ❑ Recreational Drugs ❑ Tranquilizers
❑ Antihistamines ❑ Blood Pressure Medication ❑ Insulin/Diabetes Drugs ❑ Steroids/Cortisone

Have you ever taken Phen-Fen (also known as Redux or Pondimin? ❑ Yes ❑ No

Please list additional prescription, over-the-counter drug, herbal remedies, or vitamins: _____

Are you experiencing or have you experienced the following?

❑ Abnormal Bleeding ❑ Colitis ❑ Headaches ❑ Liver Disease ❑ Shingles
❑ Alcohol Abuse ❑ Congenital Heart Disease ❑ Heart Attack ❑ Low Blood Pressure ❑ Sickle Cell Disease
❑ Anemia ❑ Diabetes ❑ Heart Murmur ❑ Lupus ❑ Sinus Problems
❑ Arthritis ❑ Difficulty Breathing ❑ Heart Surgery ❑ Mitral Valve Prolapse ❑ Steroid Therapy
❑ Artificial Bones/Joints ❑ Drug Abuse ❑ Hemophilia ❑ Pacemaker ❑ Stroke
❑ Artificial Valves ❑ Emphysema ❑ Hepatitis ❑ Persistent Cough ❑ Thyroid Problem
❑ Asthma ❑ Epilepsy ❑ Herpes ❑ Psychiatric Problems ❑ Tonsillitis
❑ Blood Transfusion ❑ Fainting Spells ❑ High Blood Pressure ❑ Radiation Treatment ❑ Tuberculosis (TB)
❑ Cancer ❑ Fever Blisters ❑ HIV+/AIDS ❑ Rheumatic Fever ❑ Ulcers
❑ Chemotherapy ❑ Glaucoma ❑ Hospitalization ❑ Scarlet Fever ❑ Venereal Disease
❑ Chicken Pox ❑ Hay Fever ❑ Kidney Problems ❑ Seizures

List any serious medical conditions you have experienced: _____

Dental History

Why have you come to the dentist today? _____

Dental Health

How would you rate your dental health? ❑ Good ❑ Fair ❑ Poor
Are you currently in pain? ❑ Yes ❑ No
Are you experiencing or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No
Do your gums ever bleed? ❑ Yes ❑ No
Do your gums ever itch? ❑ Yes ❑ No
Have you had periodontal disease? ❑ Yes ❑ No
Have you had problems with previous dental work? ❑ Yes ❑ No
Do you have mobility in your teeth? ❑ Yes ❑ No
Are your teeth sensitive to heat/cold? ❑ Yes ❑ No
Do you still have your wisdom teeth? ❑ Yes ❑ No
If yes, why? _____

Hygienic Routine

Do you floss daily? ❑ Yes ❑ No
Do you brush daily? ❑ Yes ❑ No
Type of toothbrush bristles? ❑ Hard ❑ Med. ❑ Soft
How long do you use a toothbrush before replacing it? _____
Do you use anything in addition to brush and floss? ❑ Yes ❑ No
If yes, what? _____

Dentist History

Previous/Present Dentist: _____ Last Dental Cleaning: ____
(Please Circle)
Why did you leave your previous dentist? _____
What did you like most & least about any dentist you've seen?
_____

Would you like to change anything about your smile? _____

Authorizations

I affirm that the information I have provided is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

_____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of all services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions, whether manual or electronic.

_____
Signature Date