CONFIDENTIAL MEDICAL – DENTAL HISTORY FORM
Please fill out form and return it to our front desk.

PATIENT'S NAME ______________________________ **SSN#:** ______-______-__________

I would prefer the nickname: _____________ **Email:** _________________________________

Appointment Reminders - How would you prefer to be reminded about your appointment?
Please select **one**:
Phone call to: (___)__________ Email to: __________________________ Text to: (___)___________

How did you hear about us? Website www.KiesslingFamilyDental.com**?** ☐**Yes** ☐**No** **Facebook?** ☐**Yes** ☐**No**
Referral? ☐**Yes (who referred:**________________________) ☐**No** **Other:** _____________________

Employer: ____

Home Address: ____

Date of Birth: _____________**Sex: M F** Single___ Married___ Widowed___ Separated_____ Divorced____

Home Phone #: ( ) **Work Phone:** ( ) - **Cellular #** ( )

In case of emergency, who should be notified?________________________ Phone # ________________________

Please circle if you have now or have had any of the following:

Heart Murmur	**High/Low Blood Pressure**	**Epilepsy**	**Tumor or Cancer**	**Arthritis**
Mitral Valve Prolapse	**Heart Disease**	**Diabetes**	**Radiation Therapy**	**HIV +/AIDS**
Rheumatic Fever	**Heart Attack**	**Asthma**	**Hay Fever**	**Anemia**
Artificial Joints	**Chronic Lung Disease**	**Stroke**	**Venereal Disease**	**Hepatitis**
Artificial Heart Valves	**Psychiatric Care**	**Tuberculosis**	**Fainting Spells**	**Prolonged Bleeding**
Blood Disease	**Blood Transfusion**	**Glaucoma**	**Jaundice**	**Liver Disease**
Pacemaker	**Shortness of Breath**	**Thyroid Disease**	**Sinus Trouble**	**Kidney/Bladder Trouble**

Medical Alert:

Any other serious disease/condition not listed:____

Are you allergic to any medications? **Penicillin, Aspirin, Codeine, Other**_______________________________

Are you allergic to any material? **Latex, Nickel, Other**____

List **ANY** medications you are currently taking____

____

Who is your present physician:_____________________________________ Telephone #__________________

Please list hospitalizations over the past 5 years (other than childbirth):___________________________________

____

Women – Are you or might you be pregnant now? ☐Yes ☐No If yes, when is your due date?:__________________
Are you taking Birth Control Pills? ☐Yes ☐No

*****(PLEASE COMPLETE BOTH SIDES OF THIS FORM)*****

Do you have any pain or problems with your teeth or mouth? ☐Yes ☐No
If yes, please describe____

Have you ever had excessive bleeding following a tooth extraction or other injury? ☐Yes ☐No

Do your gums bleed when brushing or flossing? ☐Yes ☐No
If yes, where____

Have you ever fainted or had a "bad experience" in a dental office? ☐Yes ☐No
If yes, describe____

Do you use tobacco products (cigarettes, dip, cigar, pipe)? ☐Yes ☐No

When was your last visit to a dentist?__________________ Was this an emergency visit? ☐Yes ☐No

Were x-rays taken? ☐Yes ☐No ☐Don't know

Are you satisfied with your smile and overall look of your teeth? ☐Yes ☐No
If no, please explain____

What can we do for you to improve your oral health and tooth function?__________________

____

____

Thank you for filling out this form completely as it enables us to assist you more effectively. If you have ANY questions, please ask us and we will be happy to help you.

The information given above is correct to the best of my knowledge.
I understand this information will be held in the strictest confidence by this office.

Patient's/Parent's Signature________________________ Date____________

*****(PLEASE COMPLETE BOTH SIDES OF THIS FORM)*****