James K. Killen, D.D.S.
Personalized Comfort

Patient Information

Today's Date _____

Patient's Name _____ Wishes to be Called _____
First *Middle Initial* *Last*

Address _____

Birth Date _____ ❍Male ❍Female If Student: Full Time/ Part Time School _____

Referred by _____

Contact Information (If Patient is a child, then provide Parents information)

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____

Insurance and Employer Information

Insured's Name _____ Relationship to patient _____

Insurance ID or Social Security # _____ Group Number _____ Insurance Carrier _____

Marital Status _____ Date of Birth _____ Employer _____

Employer's Address _____

Second Insurance and Employer Information

Insured's Name _____ Relationship to patient _____

Insurance ID or Social Security # _____ Group Number _____ Insurance Carrier _____

Marital Status _____ Date of Birth _____ Employer _____

Employer's Address _____

Emergency Information

Person to contact in case of emergency _____

Daytime Phone # _____ Relationship to patient _____

Patient Medical Information

Physician/Clinic Name _____ Phone #_____

Date last seen by physician _____If Kaiser, medical # _____

Dental History

Patient Name: _____

Intitial Concern: _____

Date of Last Dental Exam: _____

Date of Last Dental Cleaning: _____

Date of Last Full Mouth X-rays: _____

What was done at your last dental visit? _____

Previous Dentist's name: _____

1. Do you have any dental problems now? _____
2. Do you have any teeth that are sensitive to:
   a. Hot or Cold? _____
   b. Sweets? _____
   c. Biting Pressure? _____
3. Have you ever had:
   a. Orthodontic Treatment? _____
   b. Oral Surgery (Including Extractions)? _____
   c. Periodontal Treatment? _____
   d. Worn a bite plate or mouth guard? _____
4. Does food get caught between your teeth? _____
5. Do your gums bleed or hurt? _____
6. Do you smoke or chew tobacco? _____
7. Do you have difficulty or pain, or both, when opening your mouth, for instance, when yawning? _____
8. Does your jaw get "stuck," locked," or "go out"? _____
9. Do you have difficulty chewing on either side of your mouth? _____
10. Are you aware of noised in the jaw joints? _____
11. Dou you have pain in or about the ears, temples or cheeks? _____
12. Do you have tired jaws, especially in the morning? _____
13. Do you have frequent headaches? _____
14. Have you had a serious injury to your head, neck or jaw? _____
15. Habits - Do you:
    a. Clench or grind your teeth? _____
    b. Bite your cheeks or lips regularl? _____
    C. Hold objects with your teeth (such as pencils, pipe, pins, nails, fingernails)? _____
    D. Mouth breathe while awake or asleep? _____
16. Do you feel nervous about dental treatment? _____
17. Have you ever had an upsetting experience in a dental office? _____
18. Are you pleased with the appearance of your teeth? _____
19. Would you like to keep all of your teeth all of you life? _____
20. Is there anything else about having dental treatment you would like us to know? _____

_____

_____

Medical History

Patient Name _____

1. Are you under medical treatment now? Yes No

If yes, explain

_____

2. Have you been hospitalized for any surgical operation or serious illness in the last 3 Years? Yes No

If yes, explain

_____

_____

_____

3. Please list any medication including non-prescription medicine or herbs.

_____

_____

_____

_____

_____

4. Do you use recreational drugs? Yes No

If yes, what? _____

5. Are you allergic to or have you ever had any reactions to the following? *(Please check all that apply)*

- ☐ Local anesthetics (e.g. Novocaine)
- ☐ Penicillin or other antibiotics
- ☐ Codeine
- ☐ Aspirin
- ☐ Any metals
- ☐ Sulfa Drugs
- ☐ Valium
- ☐ Vicodin
- ☐ Latex
- ☐ Foods

Others: _____

6. Women:

Are you pregnant or think you may be pregnant? Yes No

Are you nursing? Yes No

Are you taking birth control pills? Yes No

7. Do you have or have you ever had any of the following? *(Please check all that apply)*

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Low Blood Pressure
- ☐ Frequently Tired
- ☐ Recent Weight Loss
- ☐ Epilepsy / Convulsions
- ☐ Eye disease
- ☐ Asthma / Emphysema
- ☐ Respiratory Problems
- ☐ Hepatitis / Jaundice
- ☐ Stomach Troubles / Ulcers
- ☐ Sexually Transmitted Disease
- ☐ AIDS or HIV Infection
- ☐ Radiation / Chemotherapy
- ☐ Artificial Joint /Valve
- ☐ Hay Fever / Allergies
- ☐ Eating disorders
- ☐ Heart Attack
- ☐ Congenital Heart Defect
- ☐ Heart Murmur
- ☐ Angina / Chest Pain
- ☐ Swollen Ankles
- ☐ Easily Winded
- ☐ Stroke
- ☐ Fainting / Seizures
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Anemia
- ☐ Leukemia
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis

8. Do you have or have you ever had any disease, condition, or problem not listed? Yes No

If yes, explain

_____

_____

_____

_____

Consent

1. The undersigned hereby authorizes Dr. Killen to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Killen to make a thorough diagnosis of the patient's dental needs.

2. I also authorize Dr. Killen to perform all recommended treatments mutually agreed upon by me and to use the appropriate medication and anesthetics as necessary. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize Dr. Killen to employ such assistance as required to provide proper care.

3. I have received a copy of the Dental Materials Fact Sheet 5/04.

4. I understand that all responsibility for **payment** for services provided by this office for myself or my dependants is mine, and **is due and payable at the time services are rendered** unless other arrangements have been made. I understand that all accounts with an outstanding balance over 60 days will accrue interest at the monthly rate of 1.67%.

5. **Appointments/Cancellations: Except for emergencies, this office provides healthcare by appointment only. Please remember this time is reserved specifically for you. If you must change an appointment, <u>we request 24 hours notice of cancellation</u>. Missed or cancelled appointments without sufficient prior notice, may result in dismissal from this office.**

Patient _____ **Date**_____ **Witness**_____

Parent or Responsible Party _____ **Relationship to Patient** _____