King Family Dental Care, P.A.

Mitchell D. King, D. D.S.

Medical History

Name____Date_____________________
(First) (Middle) (Last)
Name you preferred to be called by________________________
Address____Date of Birth_________________________________
City/State/Zip____
Phone #:(Home) ____(Work)______________________________
Social Security #____
Employer____Occupation__________________________________
Address _____________________________City/State/Zip______________________________________

In Case of Emergency, who can we contact?____
Relationship_________phone#: (Home)________________________(Work)______________________________

Circle One: Married Separated Unmarried Widowed Divorced
If married, Spouses name__________________Employer____
If unmarried, parent/guardian's name_______________________Phone#:__________________________
*Has an member of you family visited our dental clinic?_____If yes, who?__________________________________

Are you covered by dental insurance? Yes No
If yes, please provide us with the following information:
Primary Insurance Company____
Telephone Number____
Address/City/State/Zip____
Employee's Name_______________________Date of Birth_____________________________________
Social Security Number____
Circle One: Male Female
Relationship to the patient: self parent spouse other
Home address/City/State/Zip____
Employer_________________Phone Number____
Employer's Address/City/State/Zip____
Group#__________________Policy#_________________ID#___________________________

*Please notify our front desk if you have Secondary Insurance.

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I authorize you to request a credit history report. I agree to pay a $5.00 monthly rebilling charge for any balance over 30 days. I acknowledge that I am responsible for informing Dr. King about any changes in my health history prior to treatment. I understand that my health history information will be used if necessary for diagnosis of treatment by the doctors of Dr. King Family Dental Care, P.A. I further understand that a 24 hour notice must be given in the event that I must cancel an appointment. I understand that failure to give this required notice may result in a $50.00 fee per hour scheduled for appointments missed. Phone consultations are also subject to a $15.00 charge. Any returned checks will be fined $25.00 per incident. Checks written from a closed bank account will be charged $100.00 per incident and charged under felony charges for theft of service. Any court costs that have accrued from the dr-pt relationship will be owed by you.

Patients with insurance are responsible for their portion of their bills at the time of service. King Family Dental Care, P.A. does not have contracts with any insurance carriers therefore we require that your estimated share be paid on the date of service. It is not always possible to predict which services are covered by the carrier or how much they will pay for the particular service. Please that if your insurance carrier does not remit payment within 30 days, the balance will be in full from you. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to Mitchell D. King, D.D.S.

Signature:____

How did you hear about our clinic? newspaper___ phonebook___ Chamber of Commerce magazine___
friend:______________________________ another dentist: ______________________________

*********Please Complete Both Sides of this Form*********

TO THE PATIENT: Your answers are important for the protection of your health and that of the staff of King Family Dental Care. Please answer the following questions about your health for our files. Your answers are important for your treatment.

ALL ANSWERS ARE STRICTLY CONFIDENTIAL

Medical Conditions

If you have now or have had any of the following conditions, special precautions may be needed during your dental treatment.

Yes No Hepatitis-Type A, B, C, or Delta
Yes No Diabetes: insulin dependent or diet controlled
Yes No Patient in the hospital in the last 2 years
Yes No Artificial Joint replacement
Yes No Kidney Disease/Transplant/Dialysis
Yes No Cancer: Type____________.
Yes No Chemotherapy/Radiation therapy
Date____________
Yes No Are you allergic to any medicines? If Yes, please list below:
____
____
____

Yes No Venereal Disease - Date____________.
Yes No Do you use smokeless tobacco?
If yes, how frequently?____________.
Yes No Are you undergoing Psychiatric treatment

Yes No High Blood Pressure
Yes No Asthma
Yes No Tuberculosis
Yes No Seizures
Yes No Stroke: Date____________.
Yes No Hyperthyroidism
Yes No Are you pregnant?
If yes, what trimester?____________.
Yes No Do you smoke?
If yes how much?____________.
Yes No Blood Disease
Yes No Tested positive for HIV
Date____________.
Yes No Malignant hyperthermia
Yes No Do you use alcohol?
If yes, how frequently?____________.
Yes No Congenital heart lesions

Yes No Are you taking Birth control (*Note: in combination with antibiotics you birth control pills become ineffective)
Yes No Are you taking Viagra (*Note: in the event of a heart attack, administration of the nitroglycerin will be FATAL!)
Yes No Are you taking medications?
If yes, for what purpose(s)? Please list below

NAME OF DRUG	PURPOSE

Heart Problems

Yes No Murmurs
Yes No Bypass surgery
Yes No Heart attack
Date____________.
Yes No Pacemaker
Yes No Angina pectoris
Yes No Rheumatic fever
Yes No Artificial valves
Yes No Mitral Valve prolapse

Circle any of the following which you have had or have at present

Scarlet fever	Ulcers	Emphysema	Cough	Epilepsy	Hemophilia	Thyroid disease
Liver disease	Alcoholism	Drug Addiction	Pain in jaw joints	Glaucoma	Birt Defects	Anemia
Sinus trouble	Allergies/Hives	Cold sores	Sickle cell anemia	Rheumatism	Dizzy spells	Seizures
Bruise easy	Nerviousness	Fainting	Mental retardation	Arthritis	Hay fever	Cortisone medicine

When was your last physical examination?________________________Physician's Name?____________________________________
Has there been any change in your general health in the past year?____________If yes, for what reason?_________________________
Are you now under a physician's care?____________If yes, for what condition? ____________________________________
Physician's Name______________________________Physician's Address____________________________________
Is there anything related to your medical or dental history that you have not indicated above? If yes, please explain________________
____

Dental History

When was your last professional cleaning/exam?
Dentist's Name City/State
When were your last dental x-rays taken?
What is your chief concern?

Yes No Are you having pain or discomfort at this time
Yes No Do you have trouble chewing
Yes No Do you have pain in or near your ear
Yes No Have you ever been told you have a gum disease
Yes No Do your gums bleed when you floss or brush
Yes No Do you have any growths or sores in your mouth
Yes No Have you had periodontal surgery, Date ____________.
Yes No Do you have dental implants

Yes No Do you feel nervous about your dental treatment
Yes No Have you ever had a bad experience in a dental office
Yes No Have you ever fainted in a dental office
Yes No Have you ever had orthodontic treatment
Yes No Do you dislike anything about your smile
Yes No Have you ever been advised to take antibiotics prior to dental treatment
Yes No Do you bleed for an unusual amount of time following injury