KING FAMILY DENTAL CARE, P.A.

FIRST NAME	MIDDLE	LAST

NAME YOU PREFER TO BE CALLED BY:	EMAIL ADDRESS:	
SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	DATE OF BIRTH
HOME ADDRESS	CITY, STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)	CITY, STATE	ZIP CODE

HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER

EMPLOYER	ADDRESS, CITY, STATE, ZIP	PHONE NUMBER	OCCUPATION

CIRCLE ONE: MARRIED SEPARATED WIDOWED DIVORCED UNMARRIED-PLEASE FILL OUT PARENTS NAME BELOW:

PARENT'S NAME	PARENT'S ADDRESS	PARENT'S HOME PHONE #	PARENT'S CELL PHONE #

SPOUSE'S NAME	SPOUSE'S CELL PHONE #	SPOUSE'S SS#	SPOUSE'S EMPLOYER	SPOUSE'S WORK PHONE #

OTHER EMERGENCY CONTACT NAME	CONTACT'S HOME PHONE NUMBER	CONTACT'S CELL PHONE NUMBER	RELATIONSHIP TO YOU

ARE YOU COVERED BY DENTAL INSURANCE? YES NO

PRIMARY INSURANCE COMPANY	MAILING ADDRESS	CITY, STATE, ZIP

POLICY HOLDER'S NAME	POLICY HOLDER'S DOB	POLICY HOLDER'S SS#	POLICY HOLDER'S EMPLOYER

RELATIONSHIP TO POLICY HOLDER: SELF PARENT SPOUSE OTHER_____

ID#	POLICY #	GROUP #

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 TREATMENT. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR INFORMING KING FAMILY DENTAL CARE ABOUT ANY CHANGES IN MY HEALTH HISTORY PRIOR TO TREATMENT. PATIENTS WITH INSURANCE ARE RESPONSIBLE FOR THEIR PORTION OF THEIR BILL AT THE TIME OF SERVICE. KING FAMILY DENTAL CARE DOES NOT HAVE CONTRACTS WITH ANY INSURANCE CARRIERS, THEREFORE WE REQUIRE THAT YOUR ESTIMATED SHARE BE PAID NOW. I HEREBY AUTHORIZE PAYMENT OF MY GROUP INSURANCE BENEFITS TO KING FAMILY DENTAL CARE.

SIGNATURE_____**DATE**_____

HAS ANY MEMBER OF YOUR FAMILY VISITED OUR DENTAL CLINIC? IF YES, WHO?_____

HOW DID YOU HEAR ABOUT OUR CLINIC? PHONE BOOK AD FRIEND_____ ANOTHER DENTIST_____

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. If you have now or have had any of the following conditions, special precautions may be needed during your dental treatment. Your answers are important for your treatment. **ALL ANSWERS ARE STRICTLY CONFIDENTIAL.**

Yes No	Hepatitis- Type A, B, C or D	Yes No	Seizures and/or Epilepsy
Yes No	Diabetes: insulin dependent	Yes No	Stroke Date:
Yes No	Diabetes: diet controlled	Yes No	Hyperthyroidism
Yes No	HIV positive Date:	Yes No	Malignant Hyperthermia
Yes No	Kidney Disease/Transplant/Dialysis	Yes No	Congenital Heart Lesions
Yes No	High Blood Pressure	Yes No	Undergoing Psychiatric Treatment
Yes No	Latex Allergy	Yes No	Tuberculosis

Yes No	Asthma	Do you carry an inhaler? Yes No
Yes No	Pregnant	Current Trimester: Ob/Gyn Physician:
Yes No	Do you smoke	How much?
Yes No	Do you use smokeless tobacco	How often?
Yes No	Do you drink alcohol	How often?
Yes No	Artificial joint replacement	Type: Date:
Yes No	Venereal Disease	Type:
Yes No	Heart Attack	Date:
Yes No	Heart Problems **(if yes, please circle any of the below that apply to you)**	

Heart Murmur Bypass Surgery Pacemaker Angina Pectoris Rheumatic Fever Artificial Valves Mitral Valve Prolapse

Yes No	Cancer	Type:	Date of last Chemotherapy Treatment: Date of last Radiation Treatment:

Are you allergic to any medications? If YES, please list below:

Are you currently taking any medication? If yes, for what purpose? Please list below:

Name of Drug	Purpose	Name of Drug	Purpose

Please circle if you are taking any of the following medications:

Aspirin	**Birth Control Pills**	**Cortisone Medicine**	**Viagra**

- **Please note: in combination with antibiotics your Birth Control Pills can become INEFFECTIVE**
- **If you take ASPIRIN, how often and how much do you take?_____**

Circle any of the following that apply to you TODAY or in your past:

Scarlet Fever	**Birth Defects**	**Emphysema**	**Hearing Impairment**	**Ulcers**	**Anemia**	**Alcoholism**
Liver Disease	**Mental Illness**	**Drug Addiction**	**Sickle Cell Anemia**	**Cough**	**Arthritis**	**Glaucoma**
Allergies /Hives	**Bruise Easily**	**Dizzy Spells**	**Thyroid Disease**	**Cold Sores**	**Hemophilia**	**Rheumatism**

Primary Physician's Name	Primary Physician's Address	Primary Physician's Phone Number

King Family Dental Care, P.A. Confidential Dental Health Survey

Patient Name_____**Date**_____

Date of last professional dental cleaning?		
Date of last dental exam?		
Date of last dental x-rays?		
Name of previous dentist	**Address of previous dentist**	**Phone number of previous dentist**

Reason for leaving your previous dentist:_____

Circle any of the following that apply to you TODAY or in your past:

Toothache	**Pre-medicate with antibiotics before dental treatment**	**Periodontal surgery**
Trouble chewing	**Mouth ulcers or sores or growths**	**Orthodontic treatment**
Pain in jaw joints	**Gums bleed when you brush or floss**	**Bad experience with previous dentist**
Grind your teeth	**Nervous about dental treatment**	**Concern about bad breath**
Dental implants	**History of fainting during dental treatment**	**Diagnosed with Periodontal Disease**

Yes No	**Are you happy with your smile?**
Yes No	**Do you wish that your teeth were whiter?**
Yes No	**Do you feel that you have crowded or overlapped teeth?**
Yes No	**Would you be interested in straightening your teeth?**
Yes No	**Would you like to learn about how INVISALIGN clear retainers can be used to straighten your teeth?**