Dr. Tim Sulken Dr. Ryan Kinn

COMPLETE FAMILY DENTISTRY

WELCOME!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

PLEASE COMPLETE BOTH SIDES OF THIS FORM.

Today's Date: _____

About You

Name: (*Last, First, MI*)_____
I prefer to be called: _____
Gender: Male Female
Home Address: _____
_____
Email Address: _____
Birthdate: _____
Cell #:_____ Home #: _____
SS#: _____ DL#: _____
Marital Status: *(circle one)*
Single, Married, Widowed, Divorced, Partnered, Separated
Employer: _____
Work #: _____ Occupation: _____
How long there? _____
Who may we thank for referring you? _____
Other family members seen by us: _____
Previous / Present Dentist: _____
Last Visit Date: _____

Spouse/Partner Information

Name: (*Last, First, MI*) _____
Employer: _____
Work #: _____
Birthdate: _____
SS#: _____ DL#: _____

Person Responsible for Account

Name: _____
Relation: _____
Billing Address: _____
_____
Cell #: _____ Home #: _____
Employer: _____
Work #: _____
SS#: _____ DL#: _____

Primary Dental Insurance

Insurance Co. Name: _____
Address: _____
_____
Phone #: _____
Group # (plan, local, or policy #): _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: _____
Policy Owner's SS#: _____
Policy Owner's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____
Address: _____
_____
Phone #: _____
Group # (plan, local, or policy #): _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: _____
Policy Owner's SS#: _____
Policy Owner's Employer: _____

Emergency Contact

Name: _____
Relation: _____
Address: _____
Cell #: _____ Home #: _____
Work #: _____

Medical History

Do you have a personal physician? Y N
Physician: _____
Phone #: _____
Date of Last Visit: _____
Are you currently under the care of a physician? Y N
Please explain: _____
_____

Your current physical health:	Good	Fair	Poor
Do you smoke or use tobacco in any other form?		Y	N
Have you had any metal rods, pins or implants?		Y	N
Are you taking any prescription/over-the-counter or herbal supplemental drugs?		Y	N

Please list each one (please attach list if more room required):
_____
Have you taken Fosamax, or any other bisphosphonate? Y N
Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? Y N

For Women:
Are you using a prescribed method of birth control? Y N
Are you pregnant? Y N If Yes, Week#:_____
Are you nursing? Y N

Are you allergic to any of the following?

Aspirin	Y	N	Codeine	Y	N
Dental Anesthetics	Y	N	Erythromycin	Y	N
Latex	Y	N	Penicillin	Y	N
Tetracycline	Y	N	Other	Y	N

Please list any other drugs/materials that you are allergic to: _____
_____

Medical History, continued

Why have you come to the dentist today?

Do you require antibiotics before dental treatment?	Y	N
Are you currently in pain?	Y	N
Have you ever had a serious / difficult problem associated with previous dental work?	Y	N
Do you have fears about going to the dentist?	Y	N
Have you ever had gum treatment?	Y	N
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?	Y	N

Your current dental health:	Good	Fair	Poor

Do you like your smile?	Y	N
Do your gums ever bleed?	Y	N

How many times a week do you floss? _____

How many time a day do you brush? _____

Type of bristles?	Soft	Medium	Hard

How long do you use a toothbrush before replacing it?_____

Are your teeth sensitive to heat, cold or anything else? _____

Have you lost any teeth?	Y	N

If yes, why? _____

Have you ever had any of the following medical conditions?

Abnormal Bleeding	Y	N
Alcohol/Drug Abuse	Y	N
Anemia	Y	N
Arthritis	Y	N
Artificial Bones/Joints/Valves	Y	N
Asthma	Y	N
Blood Transfusion	Y	N
Cancer /Chemotherapy	Y	N
Colitis	Y	N
Congenital Heart Defect	Y	N
Diabetes	Y	N
Difficulty Breathing	Y	N
Emphysema	Y	N
Epilepsy	Y	N
Fainting Spells	Y	N
Frequent Headaches	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
Heart Surgery	Y	N
Hemophilia	Y	N
Hepatitis	Y	N
Herpes/Fever Blisters	Y	N
High Blood Pressure	Y	N
HIV+/AIDS	Y	N
Hospitalized for any reason	Y	N
Kidney Problems	Y	N
Liver Disease	Y	N
Low Blood Pressure	Y	N
Lupus	Y	N
Mitral Valve Prolapse	Y	N
Osteoporosis/Paget's Disease	Y	N
Pacemaker	Y	N
Psychiatric Treatment	Y	N
Radiation Treatment	Y	N
Rheumatic/Scarlet Fever	Y	N
Seizures	Y	N
Shingles	Y	N
Sickle Cell Disease/Traits	Y	N
Sinus Problems	Y	N
Stroke	Y	N
Thyroid Problems	Y	N
Tuberculosis	Y	N
Ulcers	Y	N
Venereal Disease	Y	N

Please list any serious medical problems that you have ever had:

_____

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 understand that the information I have given 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 service I may need during diagnosis and treatment with my informed consent.

Signature: _____ **Date:**_____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records for treatment or examination rendered, to my insurance company.

Signature: _____ **Date:**_____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials:_____ Date: _____

Doctor's comments:

Medical History Update

I have read my medical history dated _____ and confirm that it states past and present medical conditions.

Signature: _____ **Date:**_____

I have read my medical history dated _____ and confirm that it states past and present medical conditions.

Signature: _____ **Date:**_____