Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

Date ____________________

Name ______________________________ Birthdate ______________ Home Phone ______________

Address ______________________________ City ______________ State ______ Zip ________

E-mail ______________________________ Cell Phone ______________ SS# ______________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College ______________ City ______________ State ______ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer ______________________________ Work Phone ______________

Business Address ______________________________ City ______________ State ______ Zip ________

Spouse or Parent/Guardian Name ______________ Employer ______________ Work Phone ______________

Whom may we thank for referring you? ______________________________

Person to contact in case of emergency ______________________________ Phone ______________

Responsible Party

Name of Person Responsible for this Account ______________________________ Relationship to Patient ______________

Address ______________________________ Home Phone ______________

E-mail ______________________________ Cell Phone ______________

Driver's License # ______________ Birthdate ______________ Financial Institution ______________

Employer ______________________________ Work Phone ______________ SS # ______________

Is this person currently a patient in our office? ☐Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ Credit Card (Visa, MasterCard, Discover & American Express) ☐ CareCredit

Primary Dental Insurance Information

Name of Insured ______________________________ Relationship to Patient ______________

Birthdate ______________ SS # ______________________________ Home Phone ______________

Name of Employer ______________________________ Work Phone ______________

Address of Employer ______________________________ City ______________ State ______ Zip ________

Insurance Company ______________________________ Group # ______________ Policy ID # ______________

Ins. Co. Address ______________________________ City ______________ State ______ Zip ________

How much is your deductible? ______________ How much have you used? ______________ Max. Annual benefit ________

We correspond via e-mail and text – please provide the following:

Cell #1 Phone: ______________________ Cell Carrier: ______________________

Cell #2 Phone: ______________________ Cell Carrier: ______________________

Cell #3 Phone: ______________________ Cell Carrier: ______________________

Patient Medical History

Physician ______________________ Office Phone ______________ Date of Last Visit ____________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosomax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐
8. Do you have or have you had any of the following		

	Yes	No
9. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________		
10. In order to have an idea of growth potentional, please answer the following questions		
Females: a) Has Menstration started?	☐	☐
b) Are you pregnant or think you may be pregnant?	☐	☐
Males: a) Has your voice started to change?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis /Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other	☐	☐

Patient Dental History

Name of Dentist ______________________________ Date of Last Exam ____________

	Yes	No
1. Do your gums bleed while flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw? Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lip or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had ant prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? ☐..☐	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

What concerns do you have about your teeth? ______________________________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical history. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I authorize and request my insurance company pay directly to Dr. Knierim insurance benefits. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that where appropriate, credit bureau reports may be obtained. I also understand that my diagnostic records and my name may be used for educational and promotional purposes.

✗ ____

Signature of patient (or parent/guardian if minor) Date