

Welcome to the office of Kevin Barrett, D.D.S.

We are pleased that you have selected us as your dental care provider.
To help us serve you better, please complete both sides of this patient information form.

Today's Date: _____

PATIENT INFORMATION

Last Name _____ First Name _____
Address _____
City, State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile _____
Birth date _____ Sex M ___ F ___ Social Security Number _____
Employer _____
Student: Yes ___ No ___ Name of School _____
Name of Emergency Contact _____ Phone Number _____

INSURANCE INFORMATION

Last Name of Employee _____ First Name _____
Address _____
City, State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile _____
Employer _____ Relationship to Patient ___ Self ___ Spouse ___ Child ___
Birth date _____ Sex M ___ F ___ Social Security Number _____
Name of Insurance Co. _____ Phone Number _____
I.D. Number _____ Group Number _____

SECONDARY INSURANCE INFORMATION

Last Name of Employee _____ First Name _____
Address _____
City, State _____ Zip _____
Home Phone _____ Work Phone _____ Ext. _____
Employer _____ Relationship to Patient ___ Self ___ Spouse ___ Child ___
Birth date _____ Sex M ___ F ___ Social Security Number _____
Name of Insurance Co. _____ Phone Number _____
I.D. Number _____ Group Number _____

AUTHORIZATION

I certify that I have read the above information. The above questions have been answered accurately to the best of my knowledge. I authorize Dr. Kevin Barrett to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and or health practitioners. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for my payment in full.

Signature of Patient: _____
(or parent if minor)

Date: _____

DENTAL HISTORY

To help us provide you with the best possible care, please answer all questions on this dental/medical history form. All information is completely confidential.

Reason for today's visit _____

Date of last dental visit _____ Date of last cleaning _____

Former dentist _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Occupation: _____

Please answer the following questions.

- Y N** Do your gums bleed or hurt?
- Y N** Have you noticed any loose teeth or change in your bite?
- Y N** Does food tend to become caught between your teeth?
- Y N** Do you clench or grind your teeth?
- Y N** Do you have tired jaws or jaw pain?
- Y N** Do you smoke or chew tobacco?
- Y N** Do you have tooth pain?
- Y N** Have you ever had periodontal treatment?
- Y N** Have you experienced dry mouth?
- Y N** Have you experienced sores/growths in mouth?
- Y N** Have you experienced swollen or tender gums?
- Y N** Are you satisfied with the appearance of your teeth?

HEALTH HISTORY

Physician's Name _____ Date of last visit: _____

Please indicate if you have now or have had in the past:

- | | |
|--|----------------------------------|
| Y N AIDS | Y N Fainting or dizziness |
| Y N Anemia | Y N Heart murmur |
| Y N Arthritis, rheumatism | Y N Heart problems |
| Y N Artificial heart valves | Y N Tonsillitis |
| Y N Artificial joints | Y N Herpes |
| Y N Asthma | Y N High blood pressure |
| Y N Hepatitis Type _____ | Y N HIV positive |
| Y N Bypass surgery | Y N Kidney disease |
| Y N Abnormal bleeding | Y N Tuberculosis |
| w/extractions, surgery | Y N Thyroid problems |
| Y N Blood disease | Y N Low blood pressure |
| Y N Cancer | Y N Mitral valve prolapse |
| Y N Liver disease | Y N Nervous problems |
| Y N Chemotherapy | Y N Pacemaker |
| Y N Congenital heart lesions | Y N Are you pregnant |
| Y N Venereal disease | Y N Are you nursing |
| Y N Cough, persistent or bloody | Y N Psychiatric care |
| Y N Diabetes | Y N Radiation Treatment |
| Y N Emphysema | Y N Respiratory disease |
| Y N Scarlet fever | Y N Rheumatic fever |
| Y N Sinus trouble | Y N Shortness of breath |
| Y N Stroke | Y N Ulcer |
| Y N Swollen neck glands | Y N Stints/shunts |
| Y N Epilepsy | |

Please list any medical condition(s) that you have ever had:

Please list all medications you are currently taking:

Are you allergic to any of the following:

- | | |
|------------------------------|-------------------------|
| Y N Aspirin | Y N Penicillin |
| Y N Erythromycin | Y N Sulfa |
| Y N Codeine | Y N Tetracycline |
| Y N Iodine | |
| Y N Latex | |
| Y N Local anesthetics | |

Other allergies: _____