4600 River Road North, Keizer, Oregon 97303 (503)393-2264 www.KeizerFamilyDental.com

Today's Date: _______________

Last Name: ______________________________ First Name: ___________________ MI: _____ ☐ Male ☐ Female

My preferred name: ______________________ Date of Birth: _________________ SSN: ____________________________

Preferred language: ______________________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: ____ City: ______________________ Zip: __________

Home/Cell # _____________________________ Work #: ________________ Email: ________________________________

How would you prefer to receive communications from us? ☐ Phone call ☐ Text message ☐ Email ☐ Mail

Who may we thank for referring you? _______________________________ Relationship: _____________________________

Employer: ______________________________ Occupation: _______________________ How long there: _______________

Drivers License # _______________________ Other state issued ID: ______________________ Exp Date: ______________

Emergency Contact: ______________________ Relationship: _______________ Phone: _____________________________

Responsible party for account: ________________________ Relationship: ______________ Phone: __________________

Billing Address: ____ City: ______________________ Zip: ___________

Primary Dental Insurance: ____________________________________ Subscriber ID #_______________________________

Name of insured: _____________________________ Insured SSN: _____________________________ DOB: ______________

Name of Insured Employer: ________________________________ Relationship to Insured: ___________________________

Secondary Dental Insurance: __________________________________ Subscriber ID # ______________________________

Name of Insured: ____________________________ Insured SSN: ______________________________ DOB: ______________

Name of Insured Employer: ________________________________ Relationship to Insured: ___________________________

Medical History

Patient name: ______________________________ DOB: _______________ Today's date: _______________

Primary Physician: __________________________ City: ____________________Phone: ________________

Clinic Name: _______________________________ Date of last visit: __________

Please list ALL Medications, purpose and Dose. Include injections. Attach list if needed:

______________________________ ______________________________ ________________________

______________________________ ______________________________ ________________________

______________________________ ______________________________ ________________________

______________________________ ______________________________ ________________________

Are you allergic to any of the following:

☐ Latex ☐ Local Anesthetics ☐ Aspirin ☐ NSAIDS ☐ Tylenol ☐ Penicillin/Amoxicillin ☐ Sulfa

☐ Erythromycin ☐ Tetracycline ☐ Codeine ☐ Barbiturates ☐ Acrylic ☐ Metals

☐ Other ____

For Women: ☐ Pregnant/Trying to become pregnant ☐ Nursing ☐ Oral contraceptives

Please mark (x) if you have, or have ever had, any of the following:

☐ ADHD/ADD
☐ Atrial fibrulation
☐ AIDS/HIV
☐ Alzheimers disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/gout
☐ Artificial joints
☐ Artificial valve
☐ Asthma
☐ Autism spectrum
☐ Blood disease
☐ Blood transfusion
☐ Breathing problem
☐ Bruise easily
☐ Cancer
☐ Chemotherapy
☐ Chest pain
☐ Cold sores
☐ Congenital heart
☐ Convulsions
☐ Cortisone meds
☐ Cognitive delay
☐ Diabetes
☐ Dementia
☐ Depression
☐ Drug addiction
☐ Dry mouth
☐ Easily winded
☐ Emphysema
☐ Epilepsy/seizures
☐ Excessive bleeding
☐ Fainting/dizziness
☐ Frequent cough
☐ Frequent diarrhea
☐ Glaucoma
☐ Hay fever
☐ Headaches
☐ Heart attack
☐ Heart murmur
☐ Heart pacemaker
☐ Heart disease
☐ Hemophilia
☐ Hepatitis
☐ Hypertension
☐ High cholesterol
☐ Hives or rash
☐ Hypoglycemia
☐ Intestinal problems
☐ Irregular heartbeat
☐ Kidney problems
☐ Leukemia
☐ Liver disease
☐ Lung disease
☐ Osteoporosis
☐ Pain in jaw joints
☐ Psychiatric care
☐ Radiation
☐ Renal dialysis
☐ Rheumatic fever
☐ Rheumatism
☐ Scarlet fever
☐ Shingles
☐ Sickle cell disease
☐ Sinus problems
☐ Sleep apnea
☐ Spina bifida
☐ Stomach problems
☐ Stroke
☐ Swelling of limbs
☐ Thyroid disease
☐ Tonsilitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Vertigo
☐ Other not listed: ____________

Dental History

Reason for today's visit: ____

Date of last dental visit: ___________________________ Previous Dentist: ________________________________

Why did you leave your previous dentist? ____

What did you like most about any previous dentist? ____

What did you like least about any previous dentist? ____

Are you currently experiencing dental pain? ☐ NO ☐ YES If YES - Please give details:

____

How would you rate your overall dental health? ☐ Good ☐ Fair ☐ Poor

Do you now or have you ever experienced pain/discomfort in your jaw joints? ☐ NO ☐ YES

How often do you brush your teeth? _________ How often do you Floss? ___________

Are you happy with the way your smile looks? ☐ NO ☐ YES If not, what would you change if you could?

____

Please mark (X) if you have had problems with any of the following common dental concerns:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Broken fillings
- ☐ Broken teeth
- ☐ Canker sores
- ☐ Crowded/crooked teeth
- ☐ Grinding teeth
- ☐ Lip/cheek biting
- ☐ Loose teeth
- ☐ Missing teeth
- ☐ Pain in jaw joints
- ☐ Periodontal disease
- ☐ Receding gums
- ☐ Sensitivity to cold/hot
- ☐ Sore/itchy gums
- ☐ Sores/growths in mouth
- ☐ Staining/discolored teeth

I affirm 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 services I may need.

I certify that I am covered by the above stated dental insurance benefits and I assign directly to Keizer Family Dental all insurance benefits. I understand that I am responsible for payment for services rendered, copayment, deductible or non-covered services rendered. I authorize Keizer Family Dental to release information necessary to secure the payment of benefits on my behalf. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

X ____ Date: _______________________

____ ____________________________

Print name of Patient, Parent, Guardian Relationship to Patient