Timothy M. Kelly DMD PA

# Dental Health Center



Patient Name: _____ _____ ____ Today's Date: _____
**Last** **First** **MI**

Male __ Female __ Married ___ Single ___ Child ___ Other ___

I prefer to be called _____

Social Security # _____ - ____ - _____ Birth Date: ____ / ____ / ____ Your Age: _____

Home Address: _____ Apt #: _____

_____ _____ _____
**City** **State** **Zip**

**Telephone # Home: _____ Cell: _____ E-Mail: _____**

**Your Employer: _____ Work Address: _____**

_____

**Work Phone # _____Ext: _____** _____
**City** **State** **Zip**

**Referral Information**

| **Can we thank someone for referring you?** | **Or did you find us on your own?** |
|---|---|
| Family member _____ | _____ Our Website / Dr Oogle |
| Coworker _____ | _____ Radio |
| Friend _____ | _____ News letter |
| Doctor Referral _____ | _____ Other |

## Dental Insurance information

Insurance Company: _____ Group #: _____

Address: _____ Phone #: (_____) _____- _____

_____ _____ _____
City State Zip

**Name of Insured**: _____ **Social Security #** _____-____-_____ **Date of Birth** ____ / ____ / ____

Insured Employer Name: _____ Relationship to Insured _____

Address: _____

_____

Work Phone # (____) _____ - _____ Ext: _____ (if different from above)

**Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Dr. Timothy M. Kelly of the group insurance benefits otherwise payable to me. I understand that Dr. Kelly may or may not be a provider on my insurance plan however, the office will file my insurance on my behalf.**

_____ **Date: _____**

**Signature** of patient, parent or guardian

**Emergency Contact Information**

Contact Name: _____ Relationship to you? _____

Phone # (____) ____ - _____

**Person Responsible for All Account Balances: _____**
Print Name

Social Security # _____ **Signature** _____
If different from above

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## Health History



Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) **No** **Yes**

If yes, reason: _____

Are you currently receiving care? **No** **Yes** If yes, nature of care: _____

Please list all the names and phone numbers of the **Physicians** who are currently providing you care:

1. _____
2. _____
3. _____

*For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

| | | | | | |
|---|---|---|---|---|---|
| Heart Murmur (mitral valve prolapse) | No | Yes | Depression | No | Yes |
| Anemia | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes |
| Dizziness | No | Yes | Previous Biopsies | No | Yes |
| Diabetes | No | Yes | Joint Replacement | No | Yes |
| Epilepsy | No | Yes | Glaucoma | No | Yes |
| Hepatitis, Any Form | No | Yes | Abnormal Bleeding from a cut | No | Yes |
| Rheumatic Fever | No | Yes | Liver Disease (including Jaundice) | No | Yes |
| Asthma | No | Yes | Thyroid Disorder | No | Yes |
| HIV Positive or AIDS Related Complex | No | Yes | **Sleep Disturbance** | | |
| Emphysema or Respiratory Illnesses | No | Yes | Frequent Snoring | No | Yes |
| Abnormal Heart Condition | No | Yes | Chronic Fatigue | No | Yes |
| Kidney Disease | No | Yes | Difficulty Sleeping all night | No | Yes |
| Heart (Surgery, Disease, Attack) | No | Yes | Excessive Tiredness | No | Yes |
| Venereal Disease | No | Yes | Witnessed Sleep Disturbance | No | Yes |
| Fibromyalgia | No | Yes | Choking or gasping while sleeping | No | Yes |
| Cancer | No | Yes | Previous Diagnosis of Sleep Apnea | No | Yes |
| Acid Reflux | No | Yes | Using a CPAP | No | Yes |
| High/Low Blood Pressure | No | Yes | Use of an Oral Appliance for Sleep | No | Yes |

Are you required to Pre-Medicate before dental treatment with antibiotics? No Yes

Women: Are you pregnant? No Yes

Circle which applies: Planning pregnancy in near future Nursing Birth Control

Are you allergic or have you had a reaction to:

a. Local anesthetics …….. No Yes
b. Penicillin or other antibiotics …… No Yes
c. Aspirin ……..…… No Yes
d. Codeine, valium or other sedatives……..… No Yes
e. Other _____

Are you a smoker? No Yes

If so, how much do you smoke per day? _____

**Please list any medications you are currently taking:**

1. _____ For _____
2. _____ For _____
3. _____ For _____
4. _____ For _____

Comments on patient interview concerning medical history:

_____
_____
_____

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.*

_____ _____ _____

***Patient** (Print Name)* ***Patient Signature*** *Date*

Timothy M. Kelly DMD PA

_____ _____

*Doctor Signature* *Date*

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**XXXXXXXXXXXXXXXXXXXXX** **Do Not Write Below Line** **XXXXXXXXXXXXXXXXXXXXX**

**INFORMATION UPDATE**

Have you had a change in your health since your last visit? No Yes

| | | | | | |
|---|---|---|---|---|---|
| Heart (Surgery, Disease, Attack) | No | Yes | Hepatitis, Any Form | No | Yes |
| Heart Murmur (mitral valve prolapse) | No | Yes | Rheumatic Fever | No | Yes |
| Joint Replacement | No | Yes | H.I.V. Infection/AIDS | No | Yes |
| Taken Fen-phen or other diet pills | No | Yes | | | |

Have you had a visit to a physician since your last dental visit? No / Yes
Whom and for what? _____
_____
_____

Women: Are you pregnant? No / Yes Are you a nursing mother? No / Yes

Please list any medications you are currently taking:

1. _____ For: _____
2. _____ For: _____
3. _____ For: _____
4. _____ For: _____

Do you have any **allergies?** No / Yes List: _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

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## Dental Health Registration



Name _____ Date _____

Correct answers to the following questions will allow Dr. Kelly to treat you on a individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? No Yes
   If yes explain _____
2. Have you ever had any serious trouble associated with previous dental care? No Yes
3. Does dental treatment make you nervous? No Yes
4. When was your last dental examination or treatment? Date _____

### Do you currently have or ever experienced any of the following

| | | | | | |
|---|---|---|---|---|---|
| Bleeding gums | No | Yes | Loose teeth | No | Yes |
| Unpleasant taste / bad breath | No | Yes | Teeth sensitive to hot | No | Yes |
| Burning tongue or lips | No | Yes | Teeth sensitive to cold | No | Yes |
| Fever blisters lips / mouth | No | Yes | Teeth sensitive to sweets | No | Yes |
| Orthodontic treatment (braces) | No | Yes | Teeth sensitive when chewing | No | Yes |
| Do you bite your cheeks or lips | No | Yes | Food impaction between teeth | No | Yes |
| Mouth Breathing (day, night or both) | No | Yes | Teeth Sensitive upon waking up | No | Yes |

### Have you ever been diagnosed with a "TMJ" problem?

| | | |
|---|---|---|
| Does your jaw pop or click when you open your mouth? | No | Yes |
| Are you aware of any clenching or grinding of your teeth? | No | Yes |
| Do you have pain or difficulty opening your mouth wide? | No | Yes |
| Do you have a history of headaches or neck aches? | No | Yes |

1. What is most important to you about your dental health? _____
   _____
2. What do you fear the most about receiving dental care? _____
   _____
3. Are you interested in **Sedation** "Anxiety Free" dentistry? No Yes
4. Are you satisfied with the appearance of your teeth? _____
   _____