WELCOME

James J. Klump, DDS

Patient Information

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

PLEASE CIRCLE: MINOR SINGLE MARRIED DIVORCED WIDOWED SOCIAL SECURITY # _____

PATIENT'S ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP CODE _____ CELL PHONE _____

PATIENT OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ WORK PHONE _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

Responsible Party

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY # _____ BIRTHDATE _____ CELL PHONE _____

EMPLOYER _____ WORK PHONE _____

Payment in Full expected at each appointment. Cash, personal check and major credit cards accepted.

Insurance Information

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY # _____ WORK PHONE _____

NAME OF EMPLOYER _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP CODE _____

INSURANCE COMPANY _____ GROUP # _____

INS. CO. ADDRESS _____ POLICY # _____

CITY _____ STATE _____ ZIP CODE _____ PHONE _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ MAXIMUM ANNUAL BENEFIT _____

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist 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 payment of all services rendered on my behalf or my dependents.

X _____ DATE _____

Signature of patient (or parent/guardian if minor)

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Patient Medical History

PHYSICIAN'S NAME _____ OFFICE PHONE_____ DATE OF LAST EXAM_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH AN (X)

	Yes	No		Yes	No
Heart Disease			Hay Fever / Allergies		
Heart Attack			Sinus Problems		
Cardiac Pacemaker			Arthritis		
Heart Murmur			Cancer		
Mitral Valve Prolapse			Radiation Therapy or Chemo		
High Blood Pressure			Diabetes		
Rheumatic Fever			Sexually Transmitted Disease		
Stroke			AIDS / HIV Infection		
Epilepsy / Convulsions			Asthma / Respiratory Problems		
Low Blood Pressure			Hip and/or Knee Replacement		
Fainting / Seizures			Psychiatric Care / Emotional Problems		
Anemia			Eye Disorders / Glaucoma		
Excessive bleeding from cut or extraction			Tuberculosis		
Leukemia			Latex Sensitivity		
Liver Disease / Hepatitis / Jaundice			Tobacco Use If yes, how much		
Kidney Diseases			Pregnancy If yes, what month		
Thyroid Problem			Other		

Do you have any allergies to any medications or drugs? _____

Do you have any allergies to anesthetics?_____

Please list all medications you are taking including non-prescription:_____

_____

_____

Patient Dental History

NAME OF PREVIOUS DENTIST _____ **DATE OF LAST EXAM**_____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH AN (X)

	Yes	No		Yes	No
Teeth sensitive to hot or cold liquids/foods			Unfavorable dental experience		
Teeth sensitive to sweet or sour liquids/foods			Complication from extraction		
Bleeding gums while brushing or flossing			Periodontal treatment		
Feel pain to any of your teeth			Orthodontic treatment		
Any lumps or sores in or near your mouth			Do you wear dentures or partials		
Frequent blisters on lips or mouth			Mouth breather		
Pain around ear, joint or side of face			Texture of toothbrush Soft Med Hard		
Unusual sounds in ear while eating / clicking			Do you use an automatic toothbrush		
Difficulty opening or closing mouth			Frequency of brushing		
Bad breath			Dental floss		
Unpleasant taste			Fluoride supplements		
Food impaction			Have you received instructions regarding care of your teeth and gums		
Clenching or grinding teeth			Do you like your smile		
Frequent Headaches					