KENITH R. CRAIG II, D.D.S.

Patient Information

(This information is necessary for our files and will be considered confidential)

Today's Date_____

Patient's Name_____ Date of Birth_____ Age_____

____Married ____Single ___Divorced ___Separated ___Widowed

___Student/Name of School _____ City/State_____

If patient is a minor, parent or guardian's name_____

Home address _____ City _____ Zip _____

Home phone # _____ E-mail address _____

Cell phone # _____ Drivers license# _____ State___ Social Security #_____

Patient/parent employed by _____ Occupation _____

Address_____ Business Phone#_____

Spouse's name _____ Date of Birth _____ Social Security #_____

Spouse employed by_____ Occupation _____

Business address_____ Business phone# _____

Name of nearest relative not living with you_____ Relationship _____

Address_____ Home phone # _____

Name of Physician _____ City _____ Phone # _____

Former Dentist _____ City/State _____ Phone # _____

Whom may we thank for referring you to our office _____

INSURANCE INFORMATION

Primary insured's name_____ Secondary insured's name_____

Insurance Co _____ Insurance Co _____

Group/Policy#_____ Group/Policy#_____

Employer _____ Employer_____

TERMS & CONDITIONS

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency services or dental services performed without financial arrangements must be paid for at the time of the visit. We will help prepare your insurance forms to assist in collection from your insurance and credit your account, however, this office cannot render services on the assumption that our charges will be paid by an insurance company. I grant you permission to telephone me at home or work to discuss matters related to this form. I have read and understand the above conditions.

_____

Signature (Parent, if patient is a minor) Date

HEALTH QUESTIONAIRE

Yes No

- ☐ ☐ Are you in good health?
- ☐ ☐ Are you under the care of a physician?
  If yes, what is the condition being treated?_____
- ☐ ☐ Have you ever had any serious illness or operation?
  If yes, what was the illness or operation?_____
- ☐ ☐ Have you ever been hospitalized?
  If yes, what was the reason?_____
- ☐ ☐ Do you require antibiotic pre-medication for dental treatment? If Yes, which medication? _____
- ☐ ☐ Do you have any disease or condition not listed that we should be aware of?
  If yes, please explain_____

List Medications you are currently taking:

_____
_____
_____
_____

Allergies or sensitivities to:

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Barbiturates(Sleeping Pills)
- ☐ Local Anesthetic
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Other _____

Artificial Joints:

- ☐ Hip When? _____
- ☐ Knee When? _____
- ☐ Other _____ When? _____

Do you have, or have you had, any of the following: (Please check known conditions)

Cardiac Conditions:

- ☐ Angina
- ☐ Artificial Heart Valve
- ☐ Congenital Heart Lesions
- ☐ Heart Murmur When Diagnosed ____
- ☐ Heart Problems
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke

Diseases:

- ☐ AIDS
- ☐ Blood Disease
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hepatitis Type_____
- ☐ Herpes
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Respiratory Disease
- ☐ Tuberculosis
- ☐ Venereal Disease/ STD's

Other Conditions:

- ☐ Anemia
- ☐ Arthritis/ Rheumatism
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally with extraction, surgery
- ☐ Cancer Type _____
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Contact Lenses
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Fainting/Dizziness
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Low Blood Pressure
- ☐ Nervous Problems
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Swelling of Feet/Ankle
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tumor/Growth on Head/Neck
- ☐ Ulcer
- ☐ Weight Loss

Yes No

- ☐ ☐ Do you have a tobacco habit? Present User _____ Former User _____
- ☐ ☐ Have you ever taken Fen-Phen or Redux? If Yes, When? _____ For how long? _____
- ☐ ☐ Are you on or have you ever taken oral bisphosphonate treatment such as Fosamax, Boniva or Actonel?
- ☐ ☐ Have you ever taken Aredia or Zometa?
- ☐ ☐ Have you ever had any unfavorable reaction from local anesthetic?
- ☐ ☐ Have you had any serious trouble associated with previous dental treatment?
  If yes, please explain_____
- ☐ ☐ Have you ever had an upsetting experience in the dental office?
  If yes, please explain_____

How long has it been since your last dental treatment?_____ Last x-rays?_____
How do you feel about your teeth?_____
Are you satisfied with the appearance of your teeth? _____

Yes No

- ☐ ☐ Does food tend to get caught between your teeth?
- ☐ ☐ Do your gums often bleed when you brush?
- ☐ ☐ Have you experienced problems with your jaw?
- ☐ ☐ Do you grind or clench your teeth?
- ☐ ☐ Do you have popping or soreness in your jaw?
- ☐ ☐ Do you have difficulty opening or closing your mouth?
- ☐ ☐ Do you have difficulty with chewing?

Have you ever had: Orthodontic treatment? _____ When?_____ Oral surgery?_____ When?_____
Periodontal treatment? _____ When?_____ Worn a bite appliance? _____

FOR WOMEN ONLY: Are you pregnant? ☐ Yes, what month?_____ Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

I hereby certify that the above information is true and correct to best of my knowledge.

_____
Signature (Parent, if patient is a minor) Date