Thank you for selecting our dental health team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

Patient Information (CONFIDENTIAL)

Name ____________________ Birthdate __________ Phone __________

Address ____________________ City __________ State _____ Zip _____

Email ____________________ SS# __________

Check Appropriate Box: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

If Student, Name of School/College __________ City __________ State _____ ❒ Full Time ❒ Part Time

Patient or Parent/Guardian's Employer ____________________ Work Phone __________

Business Address ____________________ City __________ State _____ Zip _____

Responsible Party

Name of Person Responsible for this Account ____________________ Relationship to Patient __________

Address ____________________ Home Phone __________

Email ____________________ Cell Phone __________

Drivers License# ____________________ Birthdate __________

Employer __________ Work Phone __________ SS # __________

Is this person currently a patient on our office: ❒ Yes ❒ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full or each appointment.

❒ Cash ❒ Personal Check ❒ Visa ❒ Mastercard ❒ I wish to discuss the office's payment policy

Insurance Information

Name of Insured ____________________ Relationship to Patient __________

Birthdate __________ SS# __________ Date Employed __________

Name of Employer __________ Union or Local # __________ Work Phone __________

Address ____________________ City __________ State _____ Zip _____

Insurance Company __________ Group# __________ Policy/ID# __________

Ins Co. Address ____________________ City __________ State _____ Zip _____

Insurance Company Phone Number ____________________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❒ Yes ❒ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ____________________ Relationship to Patient __________

Birthdate __________ SS# __________ Date Employed __________

Name of Employer __________ Union or Local # __________ Work Phone __________

Address ____________________ City __________ State _____ Zip _____

Insurance Company __________ Group# __________ Policy/ID# __________

Ins Co. Address ____________________ City __________ State _____ Zip _____

Insurance Company Phone Number ____________________

Dr. Justin Kirch, DDS
Medical Health History

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

If yes, for what? ______________________________

Physician's Name: ______________________________

Are you allergic or have you had a reaction to the following...

Aspirin, Ibuprofen, or Tylenol ☐ Yes ☐ No
Codeine, Valium or Other Sedatives ☐ Yes ☐ No
Latex or Metals ☐ Yes ☐ No
Local Anesthetic ☐ Yes ☐ No
Penicillin or Other Antibiotics ☐ Yes ☐ No

Have you ever taken any kind of bisphosphonates (Fosamax, Actonel, etc)?

If so, when and how long? ______________________________

Do you use tobacco? ☐ Smoke ☐ Chew

How often? ____________ How Long? ____________

Are you currently taking any medications, drugs or pills? ☐ Yes ☐ No

If yes, please list name and dosage:

____
____
____
____

Do you consume alcohol? ☐ Yes ☐ No

How many beverages per week? ______________________________

Do you use any mood altering drugs other than those previously listed? ☐ Yes ☐ No

Do your teeth hurt? ☐ Yes ☐ No

Do your gums bleed when you brush your teeth? ☐ Yes ☐ No

Are you happy with your smile? ☐ Yes ☐ No

Do you like the shade of your teeth? ☐ Yes ☐ No

What would you change? ______________________________

Would you be interested in whitening? ☐ Yes ☐ No

Check yes or no to indicate whether or not you have had or now have the following conditions or treatments:

Condition	Yes	No
AIDS	☐	☐
Alcoholism	☐	☐
Allergies or Hives	☐	☐
Anemia	☐	☐
Arthritis/Rheumatism	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joints or Heart Valves	☐	☐
Asthma	☐	☐
Blood Transfusion	☐	☐
Bone Disease or Bone Cancer	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Chemotherapy	☐	☐
Chest Pain (Angina)	☐	☐
Chronic Cough	☐	☐
Cold Sores/Fever Blisters	☐	☐
Congenital Heart Disease	☐	☐
Contact Lenses	☐	☐
Cortisone Medicine	☐	☐
Diabetes	☐	☐
Drug Addiction	☐	☐
Emphysema	☐	☐
Epilepsy or Seizures	☐	☐
Fainting or Dizzy Spells	☐	☐
Family History of Diabetes	☐	☐
Fen-Phen or Redox	☐	☐
Glaucoma	☐	☐
Hay Fever	☐	☐
Heart Attack	☐	☐
Heart Condition	☐	☐
Heart Failure	☐	☐
Heart Murmur	☐	☐
Heart Pacemaker	☐	☐
Heart Surgery	☐	☐
Hemophilla	☐	☐
Hepatitis Type ______	☐	☐
High Blood Pressure	☐	☐
HIV Positive	☐	☐
Kidney Trouble	☐	☐
Latex Sensitivity	☐	☐
Liver Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Nervous/Anxious	☐	☐
Neurological Disorders	☐	☐
Osteoporosis	☐	☐
Psychiatric/Psychological Care	☐	☐
Radiation Therapy	☐	☐
Rheumatic Fever	☐	☐
Sickle Cell Disease	☐	☐
Sinus Trouble	☐	☐
Special or Restricted Diet	☐	☐
Stroke	☐	☐
Swollen Ankles	☐	☐
Thyroid Problems	☐	☐
Tuberculosis (T.B.)	☐	☐
Tumors	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Yellow Jaundice	☐	☐

Any disease, condition or problem not listed: ______________________________

Women

Are you pregnant or planning a pregnancy? ☐ Yes ☐ No

If yes, due date: ______________________________

Are you a nursing mother? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Signature: ______________________ **Date:** ____________ **Check if there are no changes:** ☐

Dr. Signature: ______________________ **Date:** ____________ **Date:** ____________