The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimum dental health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date _____

NAME: _____

I prefer to be called _____ Male ___ Female ___

Single ___ Married ___ Divorced ___ Widowed ___ Separated ___

Birth date:_____/_____/_____ Age _____

SS# _____

HOME ADDRESS: _____

_____

City _____State _____Zip_____

***Email:**_____

TELEPHONE NUMBERS

Hm # _____ Cell #_____

Wk# _____Other _____

EMPLOYER: _____

Employer's Address _____

_____

Occupation: _____ How long _____

Best time to reach you _____ Where _____

SPOUSE INFORMATION

His/Her Name _____

Employer:_____

Wk # _____ SS # _____

Birth date: _____/_____/_____

Emergency Contact Information
(Neighbor or Relative Not Living With You)

His/Her Name:_____

Relation: _____

Wk # (___) _____Hm# (__)_____

Address: _____

_____

City State Zip

Person Responsible for Account

His/Her Name _____

Wk # _____ Hm #_____

Billing Address _____

_____

Whom may we THANK for referring you _____

Other family members seen by us: _____

Previous dentist: _____

PRIMARY DENTAL INSURANCE

Insurance Co:_____

Ins. Address _____

City _____ State _____ Zip _____

Ins. Phone # _____

Group # _____

Insured's Name_____

Ins. DOB: _____

Social Sec. #:_____

Ins. Employer_____

Address _____

City _____State _____Zip _____

SECONDARY DENTAL INSURANCE

Insurance Co. _____

Ins. Co. Address _____

City _____State ____ Zip ___

Ins. Phone # _____

Group # _____

Insured's Name _____

Ins.DOB:_____

Ins.SS#_____

Ins. Employer _____

Address: _____

City _____State _____Zip _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize Dr. Knellinger/Dr. Verkler to furnish information to my insurance Company concerning my care. I further hereby assign all payments for dental services rendered to me, or my dependents, by the above insurance company. I understand that I am fully responsible for any portion of those services not covered by my insurance benefits.

Date :_____Signature of Authorized Person _____

Continued on back

MEDICAL HISTORY: PATIENT _____ **DATE:** _____

Physician's Name _____ Phone Number _____ Last Visit _____

Your current health is: Good _____ Fair _____ Poor _____

Are you currently under the care of a physician? Yes _____ No _____

Please list each medication you are presently taking including prescription AND over the counter drugs?

_____

_____

FOR WOMEN: Are you taking birth control pills? Yes _____ No _____

Are you pregnant? Yes ____ No ____ **Are you currently nursing?** Yes ____ No ____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Abnormal bleeding	Y	N	Liver Disease	Y	N	**HAVE YOU TAKEN OR ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING:**		
Acid reflux	Y	N	Low blood pressure	Y	N			
Anemia	Y	N	Mitral valve prolapse	Y	N			
Asthma	Y	N	Pacemaker	Y	N	Aredia (*Pamidronate*)	Y	N
Blood Thinners	Y	N	Psychiatric problems	Y	N	Fosamax (*Alendronate*)	Y	N
Cancer/Chemotherapy	Y	N	Radiation treatment	Y	N	Actonel (*Risedronate*)	Y	N
Colitis	Y	N	Rheumatic/scarlet fever	Y	N	Zometa (*Zoledronic Acid*)	Y	N
Congenital Heart Defect	Y	N	Sinus problems	Y	N	Boniva (*Ibandronate*)	Y	N
Diabetes	Y	N	Stroke	Y	N	Bonefos (*Clodronate*)	Y	N
Difficulty Breathing	Y	N	Substance abuse	Y	N	Have you ever had I.V. or oral BISPHOSPHONATES that are NOT listed above?	Y	N
Emphysema	Y	N	Thyroid problems	Y	N			
Epilepsy	Y	N	Tuberculosis	Y	N			
Frequent Headaches	Y	N	Ulcers	Y	N			
Glaucoma	Y	N	Venereal disease	Y	N			
Heart attack	Y	N				**ARE YOU ALLERGIC TO:**		
Heart murmur	Y	N	Do you now or have you ever used tobacco products?	Y	N	Aspirin	Y	N
Heart Stents/Valve Replacement	Y	N				Codeine	Y	N
Heart Surgery	Y	N	Have you quit smoking?	Y	N	Dental Anesthetics	Y	N
Hemophilia	Y	N	If so, what year? _____			Erythromycin	Y	N
Hepatitis A B C E	Y	N	Do you snore?	Y	N	Latex	Y	N
Herpes/Fever Blisters	Y	N	Have you been diagnosed with Sleep Apnea?	Y	N	Penicillin	Y	N
High Blood Pressure	Y	N				Tetracycline	Y	N
HIV/AIDS	Y	N	If yes, have you been prescribed a CPAP?	Y	N	Sulfa Drugs	Y	N
Knee/Hip replacement or implant	Y	N				**LIST BELOW ANY OTHER ALLERGIES:**		
Kidney problems	Y	N	If yes, do you wear regularly?	Y	N			
Anything you would like to discuss with the dentist in private?				Y	N			

Please list any serious medical conditions or surgical procedures that you have ever had:

CONSENT FOR EXAMINATION & X-RAYS/AUTHORIZATION FOR RELEASE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that the information will be held in the strictest confidence and is my responsibility to inform the office of any changes in my medical status. I authorize Dr. Knellinger/Dr. Verkler/Dr. Bou-Sliman to perform an oral examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize release of any information acquired in the course of my examination or treatment.

Signature: **Date:**

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MEDICAL HISTORY UPDATE

1.Date	Comments:	Signature
2.Date	Comments:	Signature
3.Date	Comments:	Signature
4.Date	Comments:	Signature