JASLEEN KLAIR D.D.S.

Patient Information

Name: _____ Date: _____
Last First MI

I prefer to be called: _____ E-mail Address: _____

Address: _____
Apartment # Street City State Zip Code

Phone (Home): _____ (Work): _____ (Cell): _____

Birth Date: _____ Age: _____ Social Security #: _____

Gender: ◯ Male ◯ Female Marital Status: _____

Employer: _____ Occupation: _____

Address: _____
Street City State Zip Code

Spouse or Responsible Party Information

The following is for ◯ The Patient's Spouse ◯ The Responsible Party (Also responsible for payment)

Name: _____ Gender: ◯ Male ◯ Female
Last First MI

Birth Date: _____ Social Security # _____ Marital Status: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Apartment # Street City State Zip Code

Employer: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Dental Coverage? ◯ Yes ◯ No

Primary

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____
Street City State Zip Code

Name of Insured: _____ Is insured a patient? ◯ Yes ◯ No
Last First MI

Birth Date: _____ Social Security #: _____

ID #: _____ Group #: _____

Address: _____
Street City State Zip Code

Employer Name: _____

Address: _____
Street City State Zip Code

Patient's Relationship To Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other _____

Secondary

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____
Street City State Zip Code

Name of Insured: _____ Is insured a patient? ◯ Yes ◯ No
Last First MI

Birth Date: _____ Social Security #: _____

ID #: _____ Group #: _____

Address: _____
Street City State Zip Code

Employer Name: _____

Address: _____
Street City State Zip Code

Patient's Relationship To Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other _____

Referral Information

Whom may we thank for referring you to our practice? ◯ Friend / Patient ◯ Relative / Patient

◯ Internet ◯ Newspaper ◯ School / Work ◯ Other _____

Name of person or office referring you to our practice _____

PATIENT'S DENTAL HEALTH

Why have you come to see us today? (e.g.: pain, checkup, etc.)_____

Previous Dentist_____ Last Visit _____**Date of last cleaning**_____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? Y N If yes, please tell us why: _____

How often do you brush? _____ Do you floss? Y N How often? _____

(Please circle for each)

Y N I clench/grind my teeth during the day or while sleeping

Y N My gums bleed while brushing or flossing

Y N I have problems eating

Y N I want my teeth straighter

Y N I have had a facial or jaw injury

Y N My gums feel tender or swollen

Y N I have had orthodontics

Y N I want my teeth whiter

I consider my health to be (circle one): Excellent Good Fair Poor

PATIENT'S MEDICAL HISTORY

Do you have or have you had any of the following? Please circle Y for yes or N for no.

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Pacemaker
7. Y N Stent
8. Y N Abnormal Blood Pressure
9. Y N Anemia
10. Y N Prolonged Bleeding Disorder
11. Y N Tuberculosis or Lung Disease
12. Y N Asthma
13. Y N Hay Fever
14. Y N Sinus Trouble
15. Y N Epilepsy/Seizures
16. Y N Ulcers
17. Y N Implants/Artificial Joints: Hip-Knee_____ Other_____
18. Y N I smoke or use chewing tobacco If yes, how much per day? _____ How many years? _____
19. Y N I have consumed alcohol within the last 24 hours.
20. Y N I usually take antibiotics prior to dental treatment.
21. Y N Have you ever taken Fen-Phen or Redux?
22. Y N Do you take or have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) for Osteoporosis or any other condition?
23. Y N I have had major surgery Year _____ Type of operation _____Year _____Type of operation _____
24. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

25. Y N Liver Disease
26. Y N Jaundice
27. Y N Hepatitis Type _____
28. Y N Diabetes
29. Y N Excessive Urination and/or Thirst
30. Y N Infectious Mononucleosis ("Mono")
31. Y N Herpes
32. Y N Arthritis
33. Y N Sexually Transmitted/Venereal Diseases
34. Y N Kidney Disease
35. Y N Tumor or Malignancy
36. Y N Cancer/Chemotherapy
37. Y N Radiation Therapy
38. Y N History of Emotional or Nervous Disorders

39. Y N HIV
40. Y N AIDS
41. Y N Immune Suppressed Disorder
42. Y N Hearing Loss
43. Y N Fainting Spells
44. Y N Glaucoma
45. Y N History of Drug Addiction

WOMEN:

46. Y N Are you on birth control meds?
47. Y N Are you / could you be pregnant?
48. Y N Are you nursing?

Doctor Notes Only:

Are you allergic to any of the following?

Please circle Y for yes or N for no

48. Y N Aspirin
49. Y N Ibuprofen
50. Y N Sulfa Drugs/Sulfites/Sulfides
51. Y N Penicillin
52. Y N Codeine
53. Y N Latex, Metals, Plastics
54. Y N Local Anesthetics (i. e., Novocaine, Lidocaine)
55. Y N Other Medications Which ones?

Please list all medications you are currently taking:

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Physician's Name _____ Phone _____

Address _____ Fax _____

In the event of an emergency please contact:

Name: _____ Relationship _____Phone _____

Name: _____Relationship _____ Phone _____

Initial medical/dental reviewed by:

X _____Date _____

Doctor's Signature

X _____ Date _____

Patient's Signature