Patient Information Form

First Name: _____ Middle: _____ Last:: _____

Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: _____ Marital Status: Single Married Divorced Separated Widowed

Home#: _____ **Work:** _____ **Cell:** _____ Email: _____

Physical Home Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____
(If different from physical address)

Employer Company Name: _____ Your Supervisors Name: _____

Employer Address: _____ Your Job Title: _____

Nearest Relative or Friend **not living with you**: _____ Phone: _____ Relation: _____

Whom may we contact in the case of an emergency? _____ **Phone:** _____ **Relation:** _____

INSURANCE INFORMATION

Is Patient a full time student? _____ If yes name and location of school: _____

Name of insured/Subscriber: _____ Relationship to patient: _____

Birth date of insured/ Subscriber: _____ SS# of insured/Subscriber: _____

Address of Insured: _____ Phone: _____

Name of Employer for Subscriber: _____ Wk Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company Name: _____ Phone: _____

Ins Co. Address: _____ City: _____ State: _____ Zip: _____

Group/Account #: _____ Insurance card ID number: _____ ***Annual Maximum$*** _____ ***Deductible$*** _____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Kai Funke DDS. I agree to be responsible for all charges for dental services and material not paid by my dental benefit plan. I consent to the use and disclosure of my protected health information to carry out payment activities in connection with my dental claims.

Signature: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? _____YES _____NO **(if yes ask for another form to fill out)**

Who referred you to our office? _____
Please provide name, we would love to send a thank you card

I will be paying today by Cash: ____ Credit Card: ____ Debit Card _____ **(Visa /MC/Discover/Amex and the card must be in your name)**

Sorry but checks are NOT accepted on the first visit (we do accept debit cards); if you have insurance you may still have a co-pay today.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have completed all of the above answers and I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I also understand that payment is expected the same day services are rendered unless prior financial arrangements have been made with the office manager. If you have insurance we will gladly help you process your claims but we require that you pay your estimated portion the day services are rendered.

_____ _____ _____

Signature of Patient Print Name Date

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MEDICAL HISTORY

Date _____ SS/HIC/Patient ID# _____

Patient Name _____ Date of Birth _____

Check (✓) if you have or have had problems with any of the following:

AIDS/HIV Positive	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Neurological Problems	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Endocarditis	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Fibromyalgia	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma or Hay Fever	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
			Hemophilia	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer Therapy	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Claustrophobia	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Tumor or growth on		
Congenital Heart Lesions	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	head or neck	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
COPD	☐ Yes	☐ No	Measles or mumps	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Nasal Obstruction	☐ Yes	☐ No			

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs. Check (✓) the medications you are presently taking, medications you have taken in the past, or medications you have had an adverse reaction to:

	Presently Taking	Taken in the Past	History of Reaction
Anesthetics, Locally Injected	☐	☐	☐
Anesthetics, General	☐	☐	☐
Antacids	☐	☐	☐
Anti-anxiety Medications	☐	☐	☐
Anti-depressants	☐	☐	☐
Antihistamines	☐	☐	☐
Daily Aspirin Regimen	☐	☐	☐
Birth Control Pills	☐	☐	☐
Blood Pressure Medications	☐	☐	☐
Cholesterol Medication	☐	☐	☐
Codeine, Demerol or Other Analgesics	☐	☐	☐
Cortisone or Other Steroids	☐	☐	☐
Coumadin, Heparin, Warfarin or other blood thinners	☐	☐	☐
Dilantin	☐	☐	☐
Diuretics (water pills)	☐	☐	☐
Fen-phen (Ionimin, adipex, Fastin, phentermine, Pondimin, fenfluramine, Redux, dexfenfluramine)	☐	☐	☐
Heart Medications such as Digoxin, Nitroglycerin or Digitalis	☐	☐	☐
Ibuprofen (Motrin)	☐	☐	☐
Insulin or Diabetes Medications	☐	☐	☐
Sedatives or Tranquilizers	☐	☐	☐
Sleeping Pills (Barbiturates)	☐	☐	☐
Thyroid Medication such as Synthroid, Levoxyl or Levothyroxine	☐	☐	☐
Tylenol (Acetomeniphen)	☐	☐	☐

Adverse reaction to any other medication or drug ☐ Yes ☐ No

Please specify _____

List the other medications you are currently taking and what condition you are taking them for. Include vitamins, supplements, herbs and over the counter medications.

Medication	Condition	Prescribing Doctor

Pharmacy Name _____ Phone ( ) _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Have you had any serious illnesses or surgeries? ☐ Yes ☐ No If yes, describe _____

Check (✓) your current use of:

Tobacco ☐ Yes ☐ No
Packs per day _____
Alcohol, Beer, Wine ☐ Yes ☐ No
Drinks per day _____
Street Drugs ☐ Yes ☐ No
Times per day _____
Caffeine ☐ Yes ☐ No
Cups per day _____
High Stress ☐ Yes ☐ No
Reason _____

Do you have any other health needs you should bring to our attention? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

DOCTORS COMMENTS ONLY

SIGNATURE OF DENTIST: **DATE:**

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DENTAL HISTORY & PATIENT GOALS

Date _____ SS/HIC/Patient ID# _____

Patient Name _____ Date of Birth _____

DENTAL HISTORY

Dental Clinic _____ Dentist's Name _____

Street Address _____ City _____ State _____ Zip _____

Phone ( ) _____ Date of Last Appt _____ Date of Last X-Rays _____

Why did you leave your previous dentist? _____

Check (✓) if you have or have had problems with any of the following:

Bad breath	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Tobacco use	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Chewing on foreign objects	☐ Yes	☐ No
Sores, blisters, growths on lips or mouth	☐ Yes	☐ No	Fingernail biting	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Thumb sucking	☐ Yes	☐ No
Biting cheeks or lips	☐ Yes	☐ No	Tongue thrusting	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Pain on brushing teeth	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No	Loose or broken teeth	☐ Yes	☐ No
Chewing	☐ Yes	☐ No	Loose or broken fillings	☐ Yes	☐ No
Swallowing	☐ Yes	☐ No	Food collection between the teeth	☐ Yes	☐ No
Talking	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Prominent gag reflex	☐ Yes	☐ No	Sensitivity to hot	☐ Yes	☐ No
Snoring	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Pyorrhea or trench mouth	☐ Yes	☐ No	Stained teeth	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No	Grinding or clenching teeth	☐ Yes	☐ No
Wisdom teeth extracted	☐ Yes	☐ No	Clicking or popping jaw	☐ Yes	☐ No
Bite problems	☐ Yes	☐ No	Jaw pain or fatigue	☐ Yes	☐ No
Missing teeth	☐ Yes	☐ No	Opening or closing jaw	☐ Yes	☐ No
Shifting position of teeth	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No

How often do you brush? _____ How often do you floss? _____

How often do you have your teeth cleaned? _____

How often do you change toothbrushes? _____

PATIENT GOALS

What is your goal for dental treatment today? _____

_____

Are you in discomfort today? ☐ Yes ☐ No

Are you pleased with the appearance of your teeth? ☐ Yes ☐ No If no, please explain _____

_____

Do you like your smile? ☐ Yes ☐ No If no, please explain _____

_____

Does dental treatment make you nervous? ☐ Yes ☐ No If yes, please explain _____

_____

Have you been pleased with your previous dental care? ☐ Yes ☐ No

Have you ever had a bad experience in a dental office? If so, explain _____

_____

How can we help improve your teeth and smile? _____

_____