

# Sugarhill Dental

*Christopher Kindig, D.M.D.*

## PATIENT INFORMATION FORM

PATIENT NAME \_\_\_\_\_ NICKNAME \_\_\_\_\_ DATE \_\_\_\_\_

LOCAL ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

ALT. ADDRESS \_\_\_\_\_ CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (     ) \_\_\_\_\_ CELL PHONE (     ) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_

REFERRED BY \_\_\_\_\_

EMAIL \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_ WORK PHONE (     ) \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

PARENT / LEGAL GUARDIAN (IF PATIENT IS A MINOR) \_\_\_\_\_

IN CASE OF EMERGENCY (CLOSEST RELATIVE OR FRIEND)

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_

**DENTAL** INSURANCE PLAN NAME \_\_\_\_\_ ID# \_\_\_\_\_ PHONE # \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_

# Christopher Kindig, D.M.D.

## MEDICAL HISTORY FORM

PATIENT NAME \_\_\_\_\_

DO YOU HAVE ANY INFLAMED AREAS, GROWTHS OR SORE SPOTS IN OR AROUND YOUR MOUTH? **YES NO**

IF YES, DESCRIBE \_\_\_\_\_

ARE THERE ANY CHANGES IN YOUR HEALTH IN THE PAST YEAR? **YES NO**

EXPLAIN: \_\_\_\_\_

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? **YES NO**

NAME OF PHYSICIAN \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST 5 YEARS? **YES NO**

IF YES, EXPLAIN \_\_\_\_\_

HAVE YOU HAD ABNORMAL BLEEDING WITH PREVIOUS EXTRACTIONS, SURGERY OR TRAUMA? **YES NO**

HAVE YOU EVER TESTED POSITIVE FOR HIV INFECTION OR AIDS? **YES NO**

HAVE YOU EVER HAD SURGERY AND/OR RADIATION FOR A TUMOR, GROWTH OR OTHER CONDITION? **YES NO**

IF SO, PLEASE STATE THE DATE OF DIAGNOSIS AND TREATING PHYSICIAN \_\_\_\_\_

### DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE ONE)

HIGH BLOOD PRESSURE	YES NO	STOMACH ULCERS, COLITIS	YES NO
HEART MURMUR OR MVP (CIRCLE)	YES NO	HEPATITIS, JAUNDICE, LIVER DISEASE	YES NO
DIABETES	YES NO	KIDNEY PROBLEMS	YES NO
JOINT PROSTHESIS (HIP, KNEE, ETC.)	YES NO	PSYCHIATRIC PROBLEMS	YES NO
RHEUMATIC HEART DISEASE OR FEVER	YES NO	FAINTING PROBLEMS	YES NO
CONGENITAL HEART DISEASE	YES NO	EPILEPSY	YES NO
CARDIOVASCULAR DISEASE, HEART ATTACK, STROKE OR BYPASS	YES NO	CANCER IF YES, WHAT TYPE	YES NO
PROSTHETIC HEART VALVE	YES NO	LOW BLOOD PRESSURE	YES NO
BLOOD DISORDER (E.G. ANEMIA)	YES NO	DO YOU SMOKE/AMOUNT _____	YES NO
VENEREAL DISEASE	YES NO	TEMPOROMANDIBULAR JOINT PROBLEMS (TMJ)	YES NO
ASTHMA	YES NO	LOW BLOOD SUGAR	YES NO
CHEST PAIN, ANGINA	YES NO	DIALYSIS	YES NO
SWOLLEN ANKLES, ARTHRITIS OR JOINT DISEASE (CIRCLE)	YES NO	IRREGULAR HEART BEAT	YES NO
CARDIAC PACEMAKER	YES NO	CONTAGIOUS DISEASES	YES NO
HEART SURGERY	YES NO	BRONCHITIS, CHRONIC COUGH	YES NO
DELAY IN HEALING	YES NO	HAY FEVER OR SINUS PROBLEMS	YES NO
TUBERCULOSIS	YES NO	PROBLEMS WITH THE IMMUNE SYSTEM	YES NO
EMPHYSEMA	YES NO	DIFFICULT BREATHING/LUNG TROUBLE	YES NO
RADIATION OR CHEMOTHERAPY	YES NO	CHRONIC FATIGUE OR NIGHT SWEATS	YES NO
ON A DIET	YES NO	HISTORY OF DRUG ABUSE	YES NO
HISTORY OF ALCOHOL ABUSE	YES NO	WEAR CONTACT LENSES	YES NO
EYE DISEASE OR GLAUCOMA	YES NO	BRUISE EASILY	YES NO

DO YOU REQUIRE AN ANTIBIOTIC PRE-MEDICATION PRIOR TO ALL ROUTINE DENTAL WORK? **YES NO**

REASON FOR PRE MEDICATION \_\_\_\_\_ ANTIBIOTIC USED? \_\_\_\_\_

ARE YOU CURRENTLY TAKING OR HAVE YOU TAKEN BISPHOSPHONATE MEDICATION, SUCH AS ACTONEL, RECLAST OR FOSAMAX WITHIN THE PAST TWELVE YEARS? **YES NO**

**ARE YOU ALLERGIC TO OR HAVE HAD ANY PROBLEMS WITH: (PLEASE CIRCLE ONE)**

PENICILLIN **YES NO** IF YES, PLEASE EXPLAIN \_\_\_\_\_  
OTHER ANTIBIOTICS **YES NO** IF YES, PLEASE LIST \_\_\_\_\_  
CODEINE **YES NO** IF YES, PLEASE EXPLAIN \_\_\_\_\_  
ASPIRIN **YES NO** IF YES, PLEASE EXPLAIN \_\_\_\_\_  
NSAIDS (I.E. ADVIL, ALEVE) **YES NO** IF YES, PLEASE EXPLAIN \_\_\_\_\_  
DENTAL ANESTHESIA **YES NO** IF YES, PLEASE EXPLAIN \_\_\_\_\_  
LATEX **YES NO** IF YES, PLEASE EXPLAIN \_\_\_\_\_  
OTHER \_\_\_\_\_

DO YOU TAKE ANY MEDICATION, INCLUDING NON-PRESCRIPTION? **YES NO**

IF YES, PLEASE LIST AND GIVE REASON FOR TAKING (OR ATTACH LIST)

\_\_\_\_\_  
\_\_\_\_\_

DO YOU TAKE VITAMIN/HERBAL SUPPLEMENTS? **YES NO**

IF YES, PLEASE LIST AND GIVE REASON FOR TAKING (OR ATTACH LIST)

\_\_\_\_\_  
\_\_\_\_\_

IS THERE ANYTHING ELSE IN YOUR MEDICAL HISTORY OF SIGNIFICANCE? \_\_\_\_\_

\_\_\_\_\_

**FOR FEMALE PATIENTS ONLY**

IS THERE A POSSIBILITY THAT YOU ARE PREGNANT? **YES NO** DUE DATE \_\_\_\_\_

ARE YOU CURRENTLY NURSING **YES NO**

ARE YOU CURRENTLY TAKING BIRTH CONTROL **YES NO**

**PLEASE NOTE: ANTIBIOTICS (SUCH AS PENICILLIN) MAY ALTER THE EFFECTIVENESS OF MANY FORMS OF BIRTH CONTROL. CONSULT YOUR PHYSICIAN / GYNECOLOGIST FOR ASSISTANCE REGARDING ADDITIONAL METHODS OF BIRTH CONTROL.**

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(OR PARENT'S OR LEGAL GUARDIAN SIGNATURE)

PLEASE PRINT PATIENT NAME \_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_, have received or been given the opportunity to read a copy of the office's Notice of Privacy Practice.

Print Patient's Name

\_\_\_\_\_

Signature of Patient

\_\_\_\_\_

Signature of Legal Guardian

\_\_\_\_\_

I hereby authorize you to share/disclose my health information with the following person(s):

\_\_\_\_\_

\*\*\*\*\*

Office Use Only

As a privacy officer, I attempted to obtain the patient's (or representative's) signature of this acknowledgment document, but did not because:

- It was an emergency
- I could not communicate with the patient/responsible party
- The patient refused to sign
- The patient was unable to sign because \_\_\_\_\_
- Other \_\_\_\_\_

**SUGARHILL DENTAL**  
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APPOINTMENT / CANCELLATION POLICY

**APPOINTMENT POLICY**

We respect our patient's time and make every effort to remain on schedule. Some visits, such as emergencies are not anticipated and could cause a delay. We will make every effort to notify you so you may choose to come later or re-schedule. If you are going to be late, we ask you notify us as soon as possible. If you are significantly delayed, your appointment may be modified or we may need to reschedule your appointment.

**CANCELLATION POLICY**

We value each of our patients and because of the level of service we provide, your appointment is especially reserved just for you. We confirm each appointment 2 days in advance as a courtesy reminder. We ask that you make every effort to give us at least a 24-hour notice if you cannot make your scheduled appointment. When you give us 24-hour notice, your reserved appointment time will be available for another patient. **For all missed or late notice cancellations there will be a \$45.00 charge to your account.**

We appreciate you understanding the value of our cancellation policy and thank you in advance for your cooperation.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_