

Kellye N. Rice, D.M.D., P.L.L.C.
Cosmetic & Family Dentistry

CONFIDENTIAL DENTAL AND MEDICAL HISTORY

[Please print]

Personal History

Date: _____

Patient's Name: _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Home Address: _____
STREET CITY STATE ZIP

Home Phone: _____ Cell Phone: _____ Email: _____

Sex: M F Age: ____ Birth Date: _____ Marital Status: S M W D

Employed by: _____ How Long: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse's Name: _____ Spouse Employed by: _____

Spouse's Business Address: _____ Spouse's Business Phone: _____

Who is responsible for this account: _____ Relationship to Patient: _____

Patient's Social Security #: _____ Spouse's Social Security # _____

| | |
|--|---|
| In case of emergency, call _____ | Relationship to Patient: _____ Phone: _____ |
| How did you learn about our dental office: <input type="checkbox"/> Referred by: _____ | |
| <input type="checkbox"/> Other, please specify: _____ | |

Financial Policy

You have been given a copy of our Financial Policy which describes payment requirements, insurance filing, appointment prepayments, and unpaid balances. Please read and sign that form.

Insurance Information

Do you have dental insurance? Yes No If yes, please complete insurance information form.

How will you be paying for today's visit? Check Cash Credit Card

I am interested in a payment plan. I would like more information. Yes No

(Please continue on the back of this form) ↗

Dental History

Reason for this visit: _____ Date of last dental visit _____

Have you ever had any of the following: (circle)

| | | | | | |
|--------------------------|-----|----|------------------------------------|-----|----|
| Bleeding gums | Yes | No | Gag easily | Yes | No |
| Food impaction | Yes | No | Complications from extractions | Yes | No |
| Burning Tongue | Yes | No | Gum treatments | Yes | No |
| Swelling in mouth | Yes | No | Teeth straightened | Yes | No |
| Lump in mouth | Yes | No | Mouth breathing | Yes | No |
| Lip or mouth blisters | Yes | No | Pipe, cigar, cigarette smoking | Yes | No |
| Clenching teeth | Yes | No | Cheek, lip, fingernail biting | Yes | No |
| Grinding of teeth | Yes | No | Major dental treatment | Yes | No |
| Bad breath | Yes | No | Unusual sounds in ear when chewing | Yes | No |
| Unpleasant taste | Yes | No | Loose teeth | Yes | No |
| Tired jaws | Yes | No | Chew on only one side of mouth | Yes | No |
| Many cavities | Yes | No | Do you snore | Yes | No |
| Loose or broken fillings | Yes | No | Do you have sleep apnea | Yes | No |

Medical History

Physician's Name _____ Date of Last Physical: _____

Have you ever had any of the following? (check boxes that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Ever taken Fen-Phen |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis, jaundice, liver disease | <input type="checkbox"/> Special diet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Swollen neck glands |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Chronic diarrhea | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Allergies to anesthetics | <input type="checkbox"/> AIDS or other immunosuppressive disorder |
| <input type="checkbox"/> Artificial heart valves or joints | <input type="checkbox"/> Allergies to medicine or drugs | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> General allergies | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chemical dependency |
| <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Lasik or other eye surgery: | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Epilepsy | Date: _____ | |

Do you have allergies or adverse reactions to any medication? ___ If so, what? _____

Have you ever taken the drug Fosamax? _____ If so, when? _____ By IV or orally? _____

Are you taking any medications at this time? _____ If so, what? _____

Are you under the care of a physician? _____ For what conditions: _____

[Women] Do you suspect that you are pregnant? _____ Are you nursing? _____

List all surgeries and their dates: _____

Is there anything else we should know about your medical history: _____

The information provided on this form is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold Dr. Rice or members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of the Notice of Privacy Practices for Kellye N. Rice, D.M.D., P.L.L.C. has been made available to me. I am signing this form on behalf of myself and any of my dependents under the age of 18 who are, or will become, patients in this office.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

