KELLOGG & LATZ
DENTISTRY

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date_____ Soc. Sec. # _____ Birthdate _____

Name _____

Address _____ Home Phone _____

Email Address _____ Cell Phone _____

City _____ State _____ Zip _____

Sex: ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Long-term Partner ❑ Divorced ❑ Widowed ❑ Separated

Employer_____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY INSURANCE

Person responsible for account_____

Relationship to Patient_____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible party employed by _____ Business Phone _____

Business Address_____ Occupation _____

Insurance Company _____

Insurance Company Address_____

Subscriber ID# _____ Group # _____

ADDITIONAL INSURANCE

Insured Name_____

Relationship to Patient_____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured employed by _____ Business Phone _____

Insurance Company _____

Insurance Company Address_____

Subscriber ID# _____ Group # _____

PLEASE COMPLETE REVERSE SIDE

DENTAL HISTORY

When was your last dental visit? _____ Last X-Rays? _____

Are you having problems that require immediate attention? ❑ Y ❑ N

Do you sip on beverages with sugar all day? ❑ Y ❑ N

Constantly snack throughout the day? ❑ Y ❑ N

Do you have: Dentures ❑ Y ❑ N Partials ❑ Y ❑ N Implants ❑ Y ❑ N

Do you have city water or well water? ❑ Y ❑ N

Do you play sports? ❑ Y ❑ N

Do you have a mouth guard? ❑ Y ❑ N

Do you use an electric toothbrush? ❑ Y ❑ N

- Floss? ❑ Y ❑ N
- Waterpick? ❑ Y ❑ N
- Toothpicks? ❑ Y ❑ N
- Go Between Brushes? ❑ Y ❑ N
- Stimulator? ❑ Y ❑ N

Are your teeth sensitive to: ❑ Hot ❑ Cold ❑ Chewing ❑ Not Sensitive

Have you bleached your teeth: ❑ Y ❑ N

Do your gums bleed, feel tender or become swollen? _____

Does food catch between your teeth? ❑ Y ❑ N If yes, where? _____

Do you have any broken teeth? ❑ Y ❑ N If yes, where? _____

Do you have any missing teeth? ❑ Y ❑ N If yes, have they been replaced? ❑ Y ❑ N

If yes, how were they replaced? ❑ Fixed bridge ❑ Partial denture ❑ Full denture

Are you happy with the replacement? ❑ Y ❑ N

Are you happy with your smile? ❑ Y ❑ N If no, what would you change? _____

Do you have fluoridated water? ❑ Y ❑ N

Have you had orthodontic (braces) treatment? ❑ Y ❑ N

Have you had your wisdom teeth removed? ❑ Y ❑ N

Have you had periodontal (gum) treatment? ❑ Y ❑ N

Does dental treatment make you feel unusually anxious or frightened? ❑ Y ❑ N

Will you share why? _____

TMJ SCREENING

Do you grind your teeth during the day? ❑ Y ❑ N

Are you aware of any clenching or grinding of your teeth at night? ❑ Y ❑ N

Do you wake up with sore or tight jaw and/or neck muscles? ❑ Y ❑ N

Do you have frequent headaches? ❑ Y ❑ N

Does your jaw joint ever click, pop or grate when opening or chewing? ❑ Y ❑ N

Do you have pain in or around your ears or in your jaw joint? ❑ Y ❑ N

Do your jaw muscles hurt when you chew? ❑ Y ❑ N

Has your jaw ever locked open? ❑ Y ❑ N

Has your jaw ever locked closed? ❑ Y ❑ N

Does your jaw ever slip? ❑ Y ❑ N

Does your jaw ever stick? ❑ Y ❑ N

Continued on next page

Do you have medical concerns that would be helpful for us to know (i.e. medications and dosages, major illnesses, surgeries)? _____

_____

_____

What are the time, economic or other considerations you would like us to understand?_____

_____

_____

If you have any concerns about gentleness or discomfort, what would you like us to know about them?

_____

_____

_____

What should we know about you in order to work most effectively with you?_____

_____

_____

What else would you like us to know about you? _____

_____

_____

Do you want to be able to maintain your teeth for the rest of your life? _____

_____

_____

Do you think you will be able to? _____

_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

1. List Past Surgeries:

   _____
   _____
   _____
   _____

2. Do you smoke or chew? ..... ❑ Y ❑ N
3. Do you use legalized Marijuana ..... ❑ Y ❑ N
4. Are you currently taking medication(s)? ..... ❑ Y ❑ N

   Please describe:_____

   _____

5. Do you use herbs? ..... ❑ Y ❑ N
6. Have you ever had any allergic reactions to the following?
   - Local anesthetics (i.e. novocaine) ..... ❑ Y ❑ N
   - Penicillin ..... ❑ Y ❑ N
   - Other Antibiotics ..... ❑ Y ❑ N
   - Sulfa drugs ..... ❑ Y ❑ N
   - Barbiturates (sleeping pills) ..... ❑ Y ❑ N
   - Sedatives ..... ❑ Y ❑ N
   - Iodine ..... ❑ Y ❑ N
   - Latex Gloves ..... ❑ Y ❑ N
   - Aspirin ..... ❑ Y ❑ N
   - Other ..... ❑ Y ❑ N
7. Are you a recovering alcoholic? ..... ❑ Y ❑ N
8. Are you a recovering drug addict? ..... ❑ Y ❑ N
9. Do you use a C-PAP machine? ..... ❑ Y ❑ N
10. Do you have sleep apnea? ..... ❑ Y ❑ N
11. Do you snore, or does someone tell you that you snore? ..... ❑ Y ❑ N
12. Do you have dry mouth / bad breath? ..... ❑ Y ❑ N
13. Are you pre-diabetic? ..... ❑ Y ❑ N
14. Do you have a family history of:
    - Periodontics ..... ❑ Y ❑ N
    - Diabetes ..... ❑ Y ❑ N
    - High Blood Pressure ..... ❑ Y ❑ N
    - Seizures ..... ❑ Y ❑ N
    - Lupus ..... ❑ Y ❑ N
    - Fibromyalgia ..... ❑ Y ❑ N
    - Acid Reflux ..... ❑ Y ❑ N

PLEASE CHECK ALL THAT APPLY

AIDS ❑
Anemia ❑
Arthritis, Rheumatism ❑
Artificial heart valves ❑
Artificial joints ❑
Asthma ❑
Back problems ❑
Bleeding abnormally, with extractions or surgery ❑
Blood Disease ❑
Cancer ❑
Chemical dependency ❑
Chemotherapy ❑
Chronic Fatigue Syndrome ❑
Circulatory problems ❑
Congenital heart lesions ❑
Cortisone treatments ❑
Cough - persistent or bloody ❑
Diabetes ❑
Dry Mouth ❑
Emphysema ❑
Epilepsy ❑
Fainting or dizziness ❑
Glaucoma ❑
Halitosis/Bad Breath ❑
Headaches ❑
Heart murmur ❑
Heart problems ❑
Hepatitis - Type ❑
Herpes ❑
High blood pressure ❑
HIV positive ❑
Jaundice ❑
Jaw pain ❑
Kidney Disease ❑
Food Allergies / Gluten ❑
Liver Disease ❑
Low blood pressure ❑
Mitral valve prolapse ❑
Nervous problems ❑
Pacemaker ❑
Psychiatric care ❑
Radiation treatment ❑
Respiratory Disease ❑
Rheumatic Fever ❑
Scarlet Fever ❑
Shortness of breath ❑
Sinus troubles ❑
Skin rash ❑
Stroke ❑
Swelling of feet/ankles ❑
Swollen neck glands ❑
Thyroid problems ❑
Tonsillitis ❑
Tuberculosis ❑
Tumor or growth on head/neck ❑
Ulcer ❑
Venereal Disease ❑

INSURANCE CLAIM INFORMATION

If you have insurance, we will help determine the coverage available to you. We will also file your insurance claim for you. Please remember that dental insurance is a contract between you and your insurance company. Insurance covers only a portion of dental fees. Payment of the bill is ultimately your responsibility. If you ever have any questions, please feel free to ask.

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

This worksheet is designed to help you begin to explore the priorities you would like us to consider during your first meeting with us. Please feel free to use it in any way which is helpful.

What prompted you to pick up the phone and call us? _____

What outcome do you have in mind for your first visit with us? _____

Please think about your previous dental experiences. Which of those experiences would you like to find in our office? _____

Which experiences would you like to avoid or eliminate? _____

What are the main problems, issues or wonderings that you would like us to help you with? _____

What are the minor ones? _____