Date_____

New Patient Registration
J. Christopher Kibler D.D.S., P.A.

Name: _____ prefer to be called: _____
Last First Middle Initial

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ ID / SS#: _____

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

Marital Status: _____ Sex: M F **Email** _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (_____)_____

Insurance Information

Person Responsible for Account: _____ SS #: _____

Relation to Patient : _____

Address (if different from patient's) _____

_____

Responsible Person Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: (_____)_____

Dental Insurance Company: _____

Contract # _____ Group # _____ Subscriber # _____

Names of dependents covered under this plan: _____

_____

Do you have additional coverage? _____

Authorization

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

DENTAL HISTORY

J.Christopher Kibler, D.D.S., P.A.

How often do you brush your teeth? _____

How many times per week do you floss? _____

Have you ever had flossing instructions? Yes / no

Do you use a regular or powered toothbrush? _____

Do you use any other cleaning aids? Yes / no If yes, what _____

Do you have any teeth that are sensitive to cold and / or hot temperatures? Yes / No If yes, where? _____

Do you have any teeth that are tender to chewing pressure? Yes / No If yes, where? _____

Do you have teeth that have ever broken or chipped? Yes / No If yes, where? _____

Do you clench or grind your teeth while asleep or awake? Yes / No

Do you have any noticeable wear on your teeth? Yes / No

Do your gums bleed when you brush or floss? Yes / No

Do you have any loose teeth? Yes / No

Do you have receding gums? Yes / No

Do you have an unpleasant mouth odor? Yes / No

Do you have any missing teeth? Yes / No

If so, have they been replaced? Yes/ No If yes, with what? _____

Do you have areas between your teeth that trap food? Yes / No Where? _____

Do you have any areas that snag or break floss? Yes / No Where? _____

Do you have any habits that might affect your mouth or teeth? (cheek biting, nail biting, ice chewing, etc.) Yes / No

What? _____

Do you regularly snore and / or breathe through your mouth while sleeping? Yes / No

Do you smoke or use other forms of tobacco? Yes / No If yes, how much? _____

Do you get frequent mouth ulcers? Yes / No

Do you get cold sores / fever blisters? Yes / No

Have you ever had orthodontic treatment? Yes / No

Have you ever had periodontal treatment? Yes / No If yes, what type of treatment? _____

Have you ever had root canal therapy? Yes / No

Have you ever had any oral surgery, such as extractions or jaw surgery Yes / No If so, what? _____

Is there anything else regarding dental treatment that you would like us to be aware of? _____

_____

Medical Information

J. Christopher Kibler, D.D.S., P.A.

Patient Name _____
Please print

Yes	No	Unsure	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any changes in your general health within the past year?

Do you have any of the following diseases or problems?
If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.

☐	☐	☐	Active Tuberculosis
☐	☐	☐	Persistent cough greater than a 3 week duration
☐	☐	☐	Are you under the care of a physician? If so, what is/are the conditions being treated?

Who is your Physician? _____ ( ) _____
name address phone

Yes	No	Unsure	
☐	☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what medications are you taking?
☐	☐	☐	Are you taking or have you recently taken any medications including non-prescription medicine? If so, what medicines are you taking?

Prescribed _____

Over the counter _____

Natural or herbal preparations _____

Yes	No	Unsure	
☐	☐	☐	Have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), or phen-fen (fentluramine-phentemine combination)?
☐	☐	☐	Do you drink alcoholic beverages? If yes, _____ # of drinks per week for _____ # of years
☐	☐	☐	Are you alcohol and/or drug dependent? If yes, have you received treatment? _____ Yes _____ No
☐	☐	☐	Do you use tobacco products? If so, how interested are you in stopping? _____
☐	☐	☐	Do you wear contact lenses?

Are you allergic to or have you had a reaction to:

Yes	No	Unsure		Yes	No	Unsure	
☐	☐	☐	Local anesthetics	☐	☐	☐	Latex
☐	☐	☐	Aspirin	☐	☐	☐	Iodine
☐	☐	☐	Penicillin or other antibiotics	☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Barbiturates, sedatives or sleeping pills	☐	☐	☐	Animals
☐	☐	☐	Sulfa drugs	☐	☐	☐	Food (specify)
☐	☐	☐	Codeine or other narcotics	☐	☐	☐	Other (specify)

To yes responses, specify type of reaction you experienced _____

_____

(Women Only)

Yes	No	Unsure	
☐	☐	☐	Are you pregnant?
☐	☐	☐	Are you nursing?
☐	☐	☐	Are you taking birth control pills?

Medical Information, cont.

J. Christopher Kibler, D.D.S., P.A.

Yes	No	Unsure	
☐	☐	☐	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this operation done? _____
☐	☐	☐	Have you had any complications of difficulties with your prosthetic joint?
☐	☐	☐	Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? If so, what antibiotics and what dose?

Name of physician or dentist _____ Phone _____

Please (x) if you have any of the following diseases or problems:

Yes	No	Unsure	
☐	☐	☐	Abnormal bleeding
☐	☐	☐	AIDS or HIV infection
☐	☐	☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Blood transfusion If yes, date _____
☐	☐	☐	Cancer/chemotherapy/ radiation treatment
☐	☐	☐	Cardiovascular disease If yes, specify below: O Angina O Arteriosclerosis O Artificial heart valves O Coronary insufficiency O Coronary occlusion O Damaged heart valves O Heart attack O Heart murmur O High blood pressure O Inborn heart defects O Mitral valve prolapse O Pacemaker O Rheumatic heart disease
☐	☐	☐	Chest pain upon exertion
☐	☐	☐	Chronic pain
☐	☐	☐	Persistent diarrhea
☐	☐	☐	Disease, drug or radiation induced immuniosuppression
☐	☐	☐	Diabetes If yes, specify below: O Type I insulin dependent O Type II
☐	☐	☐	Dry Mouth
☐	☐	☐	Eating disorder If yes, specify _____
☐	☐	☐	Epilepsy
☐	☐	☐	Fainting spells or seizures
☐	☐	☐	Reflux
☐	☐	☐	Glaucoma

Yes	No	Unsure	
☐	☐	☐	Hemophilia
☐	☐	☐	Hepatitis, jaundice, or liver disease
☐	☐	☐	Recurrent infections Indicate type of infection: _____
☐	☐	☐	Kidney problems
☐	☐	☐	Low blood pressure
☐	☐	☐	Mental health disorders If yes, specify below: _____
☐	☐	☐	Malnutrition
☐	☐	☐	Migraines
☐	☐	☐	Night sweats
☐	☐	☐	Neurological disorders If yes, specify below: _____ _____
☐	☐	☐	Osteoporosis
☐	☐	☐	Respiratory problems If yes, specify below: O Bronchitis O Emphysema
☐	☐	☐	Severe headaches
☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Sinus trouble
☐	☐	☐	Sleep disorder
☐	☐	☐	Sores or ulcers in the mouth
☐	☐	☐	Stroke
☐	☐	☐	Systemic lupus erythematosus
☐	☐	☐	Thyroid problems
☐	☐	☐	Tuberculosis
☐	☐	☐	Ulcers
☐	☐	☐	Excessive urination
☐	☐	☐	Do you have any disease or condition or problem not listed above that you think your doctor should know about?

Note: **Both doctor and patient are encouraged to discuss any and all relevant patient health questions prior to treatment.**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I also understand that any photographs taken before, during or after treatmentt will be used for educational and diagnostic purposes

Signature of patient or legal guardian _____ **Date** _____