Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Any health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No	☐ N/A	Explain:
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	☐ N/A	Explain:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	☐ N/A	Explain:
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	☐ N/A	Explain:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	☐ N/A	Explain:
Are you on a special diet?	☐ Yes	☐ No	☐ N/A	Explain:
Do you use tobacco?	☐ Yes	☐ No	☐ N/A	Explain:
Do you use controlled substances?	☐ Yes	☐ No	☐ N/A	Explain:

Are you…	Pregnant/Trying to get pregnant?	Nursing?	Taking oral contraceptives?
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Are you allergic to allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Diseases	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/ Failure	☐ LBP	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/ Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruises Easily	☐ Fainting Spells/Dizziness	☐ HBP	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had a serious illness not listed above? ☐ Yes ☐ No ☐ N/A _____

Comments: _____

_____

_____

_____

_____

*Condition may require medication

N/A- Not Answered

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient/Parent/Guardian Date

Patient Dental History

Patient Name:			Today's Date:		
Reasons for today's visit:					
Previous Dentist (Name and Location):					
Last Dental Visit:			Last X-Rays Taken:		
How often do you brush your teeth?			How often do you floss your teeth?		
Type of toothbrush you use? ☐ Automatic ☐ Manual	☐ Hard	☐ Medium	☐ Soft	Type of toothpaste?	
Is your drinking water fluoridated?			☐ Yes	☐ No	
Do your gums bleed while brushing or flossing?			☐ Yes	☐ No	
Are your teeth sensitive to hot or cold?			☐ Yes	☐ No	
Are your teeth sensitive to sweet or sour?			☐ Yes	☐ No	
Do you feel pain in any of your teeth?			☐ Yes	☐ No	
Do you have any sores/lumps in your mouth/lips?			☐ Yes	☐ No	
Have you had any head, neck, or jaw injuries?			☐ Yes	☐ No	
Have you experienced any of the following problems with your jaw?					
Clicking? Popping?			☐ Yes ☐ Right ☐ Left	☐ No	
Pain (Joint, Ear, or side of Face?)			☐ Yes	☐ No	
Difficulty opening or closing your mouth?			☐ Yes	☐ No	
Difficulty with chewing?			☐ Yes	☐ No	
Do you bite your lips or cheeks?			☐ Yes	☐ No	
Have you noticed any loose teeth?			☐ Yes	☐ No	
Have you had any previous periodontal (gum disease) treatment?			☐ Yes	☐ No	
Have you had any difficulty with extractions in the past?			☐ Yes	☐ No	
Have you had any prolonged bleeding after any procedure?			☐ Yes	☐ No	
Do you wear dentures or partial dentures? If yes, date of placement?			☐ Yes	☐ No	
Do you wear a night guard or an orthodontic appliance?			☐ Yes	☐ No	
Have you had previous orthodontic treatment?			☐ Yes	☐ No	
Do you have frequent headaches?			☐ Yes	☐ No	
Do you clench or grind your teeth?			☐ Yes	☐ No	
Have you had previous tooth whitening treatments?			☐ Yes	☐ No	
If yes, what type?	☐ Whitening Strips	☐ Trays at home	☐ 1 hour in office treatment		
If you could change anything about your smile, what would it be?					

AUTHORIZATION AND RELEASE

I certify that I have read and answered the above questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my own or my child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered top me or my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request that my dental insurance company pay directly to the dentist for my dental services. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf.

X_____ _____

Signature of Patient/Guardian Date

X_____ _____

Signature of Doctor Date

Kelly S. Kennan, D.D.S., P.C.
1412. S. Salisbury Blvd. Suite #6 Salisbury, MD 21801
Phone 410-742-4339 Fax 410-742-6543

Welcome! Thank you for selecting our Dental Healthcare Team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

Today's date:				
About you (Confidential)				
Patient's last name: First: Middle		☐ Mr. ☐ Miss ☐ Ms. ☐ Dr. ☐ Mrs.		
Marital status (circle one) Minor/ Single/ Married/ Divorced/ Widowed/ Separated				
Soc. Sec #:	Email:	Birth date: / /	Age:	Sex: ☐ M ☐ F
Street address:	Home phone:	Cell phone:		
City:	State:	ZIP Code:	Driver's License #:	
Occupation:	Employer:	Work Phone:		
Employer Address:				
If student, name of school/college:	City:	State:	ZIP Code:	
Spouse or Parent's Name:	Spouse or Parent's Employer:			
Work Phone:	Whom May We Thank for Referring You:			
Account Information				
Person Ultimately Responsible for Bill:		Phone:		
Address (if different):		Birth Date: / /		
Soc. Sec. #:	Driver's License #:	Work Phone:		
Is this person a patient here? ☐ Yes ☐ No	Employer:	Employer Address:		
City:	State:	ZIP Code:		
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is expected at each appointment.	☐ Cash ☐ Check ☐ VISA ☐ Master Card ☐ Care Credit ☐ I wish to discuss the office's payment policy			
Insurance Information				
Primary Dental Insurance Co. Name:	Address:			
City:	State:	ZIP Code:	Phone:	
Insured's Soc. Sec #:	Group #:	Subscriber ID #:		
Subscriber's Name:	Birth Date: / /	Relationship to Patient:		
Insured's Employer:				
Secondary Insurance Co. Name (if applicable):	Address:			
City:	State	ZIP Code:	Phone:	
Insured's Soc. Sec. #:	Group #:	Subscriber ID #:		
Subscriber's Name:	Birth Date: / /	Relationship to Patient:		
Insured's Employer:				
In the Event of an Emergency				
Who should we contact?	Relation:	Phone #:		
Who is your medical doctor?	Doctor's Phone:			