Smile Designs Family Dentistry

*Shannon Kemper, DMD PSC*

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**PATIENT INFORMATION Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex Male Female Age\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

0

Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile/Alt. Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* ***IN CASE OF AN EMERGENCY, CONTACT:***

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL INSURANCE**

* ***Primary Dental Insurance***

Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* ***Secondary Dental Insurance***

Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have dental insurance coverage with the above-named dental insurance and assign directly to *Dr. Shannon Kemper* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services determining insurance benefits or the benefits payable or related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

Reason for today’s visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental x-rays\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you brush? \_\_\_\_\_\_\_\_\_\_\_

*Please check any that apply:*

Bad breath \_\_\_\_ Gums swollen or tender \_\_\_\_

Bleeding gums \_\_\_\_ Lip or cheek biting \_\_\_\_

Blisters on lips/mouth \_\_\_\_ Loose teeth or broken fillings \_\_\_\_

Burning sensation on tongue \_\_\_\_ Mouth breathing \_\_\_\_

Chew on one side of mouth \_\_\_\_ Mouth pain, brushing \_\_\_\_

Pain around ear \_\_\_\_ Orthodontic treatment \_\_\_\_

Cigarette, pipe, or cigar smoking \_\_\_\_ Pain around ear \_\_\_\_

Clicking or jaw popping \_\_\_\_ Periodontal treatment \_\_\_\_

Dry mouth \_\_\_\_ Sensitivity to cold \_\_\_\_

Fingernail biting \_\_\_\_ Sensitivity to heat \_\_\_\_

Food collection between the teeth \_\_\_\_ Sensitivity to sweets \_\_\_\_

Foreign objects \_\_\_\_ Sensitivity when biting \_\_\_\_

Grinding teeth \_\_\_\_ Sores or growths in your mouth \_\_\_\_

**HEALTH HISTORY**

Physicians Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, and Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as “fen-phen?” Those include combinations of lonimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine) and Redux(dexfenfluramine). Yes No

*Please check any that apply:*

AIDS/HIV \_\_\_\_\_ Epilepsy \_\_\_\_\_ Respiratory Disease \_\_\_\_\_

Anemia \_\_\_\_\_ Fainting/Dizziness \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_

Arthritis \_\_\_\_\_ Glaucoma \_\_\_\_\_ Scarlet Fever \_\_\_\_\_

Artificial Heart Valves \_\_\_\_\_ Headaches \_\_\_\_\_ Shortness of breath \_\_\_\_\_

Artificial Joints \_\_\_\_\_ Heart Murmur \_\_\_\_\_ Sinus Trouble \_\_\_\_\_

Asthma \_\_\_\_\_ Heart Problems \_\_\_\_\_ Skin Rash \_\_\_\_\_

Back Problems \_\_\_\_\_ Hepatitis Type: \_\_\_\_\_ Special Diet \_\_\_\_\_

Bleeding abnormally, with Herpes \_\_\_\_\_ Stroke \_\_\_\_\_

extractions or surgery \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Swollen Feet/Ankles \_\_\_\_\_

Blood Disease \_\_\_\_\_ Jaundice \_\_\_\_\_ Swollen Neck Glands \_\_\_\_\_

Cancer \_\_\_\_\_ Jaw Pain \_\_\_\_\_ Thyroid Problems \_\_\_\_\_

Chemical Dependency \_\_\_\_\_ Kidney Disease \_\_\_\_\_ Tonsillitis \_\_\_\_\_

Chemotherapy \_\_\_\_\_ Liver Disease \_\_\_\_\_ Tuberculosis \_\_\_\_\_

Circulatory Problems \_\_\_\_\_ Low Blood Pressure \_\_\_\_\_ Tumor/growths \_\_\_\_\_

Congenital Heart Lesions \_\_\_\_\_ Mitral Valve Prolapse \_\_\_\_\_ Ulcer \_\_\_\_\_

Cortisone Treatments \_\_\_\_\_ Nervous Problems \_\_\_\_\_ Venereal Disease \_\_\_\_\_

Cough, persistent/bloody \_\_\_\_\_ Pacemaker \_\_\_\_\_ Weight Loss, unexplained \_\_\_\_\_

Diabetes \_\_\_\_\_ Radiation Treatment \_\_\_\_\_

*Women:*

Are you pregnant? Yes No Due date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you nursing? Yes No

Taking birth control pills? Yes No

**MEDICATIONS**

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**

* Aspirin
* Barbiturates (Sleeping pills)
* Codeine
* Iodine
* Latex
* Local Anesthetic
* Penicillin
* Sulfa
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_