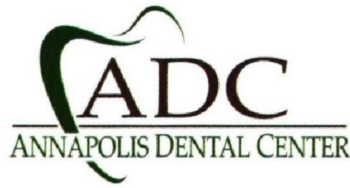

CONFIDENTIAL PATIENT INFORMATION

Today's Date: _______/_______/_______

Patient Name: ____ **Preferred Name:** _________________________
Last **First** **M.I.**

Date of Birth: ______/______/______ Social Security #: ________________________ E-Mail: ____

Address: ____ City: ______________________________ State: _______ Zip: ____________

Home Phone: ____________________________ Work Phone: __________________________ Cell Phone: ______________________________

Patient's/Parent's Employer: ____ Occupation: ___________________________

Gender: (Circle One) **Male Female** Status (Circle One) **Minor Single Married Separated Divorced Widowed**

Name of Parent/Spouse: __________________________________ Employer: _________________________ Work Phone: __________________

Person Responsible for This Account (if patient is a minor): ____

Relationship to Patient: __________________________ Date of Birth: _______/_______/_______ Social Security #: _________________________

Address (if different than above): ____________________________________ City: _______________________ State: _______ Zip: ____________

Home Phone: ____________________________ Work Phone: __________________________ Cell Phone: ______________________________

Primary Insurance Company: ____ Insurance Phone: __________________________________

Primary Insurance Subscriber: ______________________________ Employer: ________________________ Date of Birth: ______/______/______

Social Security #: ______________________ Subscriber ID: ____________________________________ Group # ___________________________

Do you have Secondary Dental Insurance? Yes No Secondary Insurance Company: _________________________ Insurance Phone: ___________

Secondary Insurance Subscriber: ______________________________ Employer: _________________________ Date of Birth: ______/______/______

Social Security #: ______________________ Subscriber ID: ____________________________________ Group # ___________________________

Is anyone in your family already a patient at this office? **Yes No** If yes, Name: ____

How did you hear about our office? (Circle One) **Google Yelp Facebook Insurance Co. Friend/Family** ____________________________

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. 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 dependents.

I understand that under the Health Insurance Portability and Accountability Act (HIPPA) of 1996, I have certain privacy rights regarding my protected health information and uses for such information. I have received a copy of Annapolis Dental Center Notice of Privacy Practices, read, and understand these practices. I understand that these practices may be changed at any time. I understand I may request in writing restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations. Annapolis Dental Center may not agree to such requests, but if agreed to then Annapolis Dental Center is bound by that request.

Signature of Patient **(or parent/guardian if minor):** ____ ***Date:*** ______/______/______

KENNEDY DELE, DMD

Annapolis
DENTAL CENTER

161. B. Jennifer RD.
Annapolis MD, 21401
410-571-5014

PATIENT MEDICAL AND DENTAL HISTORY

Patient Name: ______________________ ***Today's Date:*** ___/___/___

Emergency Contact: ______________ **Relationship:** ______________ **Phone:** ______________

Physician: ______________ **Phone:** ______________ **Last Exam Date:** ___/___/___

Previous Dentist: ______________ **X-Rays:** ______________ **Last Exam Date:** ___/___/___

Are you currently under medical treatment? ☐ Yes ☐ No **If Yes, please explain:** ______________

Please explain any surgery or serious illness you have had in the last 5 years: ______________

Please list any medications that you are taking, including non-prescription medications, herbs, vitamins, and oral contraceptives:

Medication	*Dosage*	*Reason*

Please list any medications that you are allergic to, or have had a reaction to: ______________

Are you allergic to Latex? ☐ Yes ☐ No **Do you use tobacco?** ☐ Yes ☐ No

WOMEN: Are you preganant or think you may be pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Please check any of the following conditions that you have, or have had in the past:

- ☐ High Blood Pressue
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Angina
- ☐ Chest Pains
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ Heart Murmur*
- ☐ Mitral Valve Prolapse*
- ☐ Cardiac Pacemaker
- ☐ Stroke
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Easily Winded
- ☐ Frequently Tired
- ☐ Anemia
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Thyroid Problem
- ☐ HIV/AIDS
- ☐ Epilepsy/Convulsions
- ☐ Fainting/Seizures
- ☐ Cancer or Leukemia
- ☐ Radiation Therapy
- ☐ Hepatitis/Jaundice
- ☐ Liver Disease
- ☐ Stomach Ulcers
- ☐ Glaucoma
- ☐ Recent Weight loss
- ☐ Arthritis
- ☐ Joint Replacement*
- ☐ Joint Implant*
- ☐ Swollen Ankles
- ☐ Bleeding or Clotting Problems
- ☐ Artificial Stents or Shunts

**If you have any of the conditions with an asterisk (*), please contact our office prior to your appointment, as you may require Pre-Medication.*

Reason for today's visit: ______________

Please circle Yes (Y) or No (N) in response to the following:

- **Y N** Is fluoride taken in any form?
- **Y N** Bad breath?
- **Y N** Brush daily?
- **Y N** Floss daily?
- **Y N** Headaches, ear aches, or neck pain?
- **Y N** Gums bleed when you brush?
- **Y N** Facial pain?
- **Y N** Periodontal gum treatments?
- **Y N** Orthodontic (braces) treatment?
- **Y N** Clicking or popping in jaw joints?
- **Y N** Removable dental appliances?
- **Y N** Injuries to teeth or jaw? If Yes, please explain ______________
- **Y N** For your child, any mouth habits? (thumb sucking, pacifier, nail biting, etc.)

Have you had a serious/difficult problem associated with any previous dental treatment? ☐ Yes ☐ No

If Yes, please explain: ______________

How would you describe your current dental health? ______________

How do you feel about your teeth's appearance? ______________

Would you like to hear about ways we can improve the look of your smile? ☐ Yes ☐ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient** (or parent if minor):* ______________ ***Date: ___/___/___