

Kyle G. Keeter, DDS - Courtney Geiger, DDS

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Comprehensive and Cosmetic Dentistry

Email Address: _____ DOB: _____ Social Security No. : _____

Employer: _____ Position/Title: _____ No. of Yrs: _____

Spouse's Name: _____ Phone: _____

Guardian's Name (If minor): _____ Phone: _____

Emergency Contact: _____ Phone: _____

Other family members seen by us: _____

Referred by: _____

Do you have dental insurance? Y N

If you have dental insurance through someone else other than yourself, please provide their information below:

Name: _____ Employer: _____

Social Security No. : _____ DOB: _____

MEDICAL HISTORY

Physician's Name: _____ Date of last exam: _____

Please list any prescription/over the counter medications you are taking:

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Please circle if you have ever had any of the following diseases or medical conditions:

- | | | |
|-------------------------------------|--|--------------------------------------|
| Y N Aids/HIV Positive | Y N Heart murmur/Mitral valve prolapse | Y N Pacemaker |
| Y N Allergies | Y N Heart problems/Chest pains | Y N Rheumatic/Scarlet fever (circle) |
| Y N Anemia | Y N Hepatitis A,B, or C (circle one) | Y N Sinus problems |
| Y N Cancer/Chemo/Radiation (circle) | Y N Herpes | Y N Stomach/Digestive problems |
| Y N Diabetes | Y N High blood pressure | Y N Stroke |
| Y N Eating Disorder | Y N Kidney/Urinary problems | Y N Tobacco use (what form?) _____ |
| Y N Epilepsy/Seizures | Y N Low blood pressure | Y N Ulcer |
| Y N Glaucoma | | |

Y N Have you taken an oral or I.V. bisphosphonate drug? (i.e. Fosamax, Actonel, Boniva, etc.)

Y N Have you had a joint replacement surgery? What type? _____

Y N Are you pregnant or nursing?

Please list any other medical condition(s) that we should be aware of: _____

Have you had an undesirable or allergic reaction to:

Y N Aspirin

Y N Latex

Y N Dental anesthetics

Y N Pain medication(List) _____

Y N Antibiotics (List) _____

Y N Other _____

Name of previous dentist: _____ Date of last dental visit: _____

Have you had dental X-rays taken in the past year? Y N Date of last cleaning: _____

What is the purpose of your dental visit today? _____

Do any of the following apply to you?

Y N Discomfort in the mouth

Y N Bad odor or taste

Y N Have partials/Dentures

Y N TMJ (jaw joint) problems

Y N Grinding or clenching

Y N Have a night guard

Y N Sores or growths in mouth

Y N Frequent headaches

Y N Dry mouth

Y N Orthodontic treatment

Y N Gum recession

Y N Bleeding gums

Y N Is your present dental health good?

Y N Snoring/Sleep apnea

Y N Use CPAP _____ Snore Appliance _____

Y N Are your teeth sensitive to:

___Heat ___ Aches spontaneously

___Cold ___ Pressure ___ Pain when biting

How many times a day do you brush? _____ How often do you floss? _____

Have you had previous bad experiences with dentistry? _____

What, if anything, would you change about your teeth/smile if you could? _____

Y N Are you interested in straightening your teeth?

Y N Do you think your teeth could be whiter?

Are there any concerns or topics you wish to discuss in detail? _____

The information provided today is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I understand that I'm responsible for all charges in full at the time of service unless prior arrangements have been approved.

Patient Signature

Date