Kyle G. Keeter, DDS ● Courtney L. Geiger, DDS

Samuel D. Ellsworth, DDS, MS

Comprehensive and Cosmetic Dentistry

Today's Date: _____

Last Name: _____ First Name: _____ MI:_____

Circle One: Dr. Mr. Mrs. Miss Ms. Preferred Name: _____

Address: _____ City: _____State:_____ Zip: _____

Home Phone: _____ Work: _____ Ext._____ Cell:_____

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

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