

WELCOME

N. Paul Kline DDS
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Office: 602-978-1600
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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 your dental 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!

Patient# _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birth date _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
If Student, Name of School/College _____ City _____ State _____ Zip _____
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian Name _____ Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this Person Currently a Patient in our Office? Yes No

For your convince, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card Capital One Financing Option

Insurance Information

Name of Insured _____ Relationship _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ Sate _____ Zip _____
Insurance Company _____ Group # _____ Policy/ ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITONAL INSURANCE? Yes No If Yes, Complete the following:

Name of Insured _____ Relationship _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ Sate _____ Zip _____
Insurance Company _____ Group # _____ Policy/ ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now?.....Yes No

2. Have you ever been hospitalize for any surgical operation or serious illness with in the last 5 years?.....Yes No
If yes, please explain _____

3. Are you taking any medication(s) Including non-prescription medicine?.....Yes No
If yes, what medication(s) are you taking? _____

4. Do you use tobacco?.....Yes No

5. Do you use controlled substances?..... Yes No

6. Are you wearing contact lenses?.....Yes No

7. Do you have or have you had any of the following:
Check Yes or No for each question
If unknown please leave blank

8. Are you allergic to or have had any reactions to the following:

Local Anesthetics (i.e. Novocain)..... Yes No

Penicillin or any other Antibiotics..... Yes No

Sulfa Drugs..... Yes No

Barbiturates..... Yes No

Sedatives..... Yes No

Iodine..... Yes No

Aspirin..... Yes No

Any Metals (i.e. Nickel, mercury etc.)..... Yes No

Latex Rubber..... Yes No

Other (please list) _____ Yes No

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more then 3 weeks?)

11. Women only:

Are you pregnant or think

You may be pregnant?..... Yes No

Are you nursing?..... Yes No

Are you taking oral contraceptives?..... Yes No

	Yes	No
High Blood Pressure		
Heart Attack		
Rheumatic Fever		
Swollen Ankles		
Fainting/Seizures		
Asthma		
Low Blood Pressure		
Epilepsy/Convulsions		
Leukemia		
Diabetes		
Kidney Diseases		
AIDS or HIV Infection		
Thyroid Problem		

	Yes	No
Heart Disease		
Cardiac Pacemaker		
Heart Murmur		
Angina		
Frequently Tired		
Anemia		
Emphysema		
Cancer		
Arthritis		
Joint Replacement or Implant		
Hepatitis/Jaundice		
Stomach Troubles/Ulcers		
Chest Pains		

	Yes	No
Easily Winded		
Stroke		
Hay Fever/Allergies		
Tuberculosis		
Radiation Therapy		
Glaucoma		
Recent Weight Loss		
Liver Disease		
Heart Disease		
Respiratory Problems		
Mitral Valve Prolapse		
STD		
Other		

Patient Dental History

Name of Previous Dentist and location _____ Date of last Exam _____

PLEASE CHECK ANY OF THE BELOW THAT APPLY TO YOUR DENTAL HEALTH

- | | |
|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Do your gums bleed while brushing? | <input type="checkbox"/> Do you have any lumps or sores in or near your mouth? |
| <input type="checkbox"/> Do your gums bleed while flossing? | <input type="checkbox"/> Have you had any head, neck or jaw injuries? |
| <input type="checkbox"/> Do your gums feel swollen or tender? | <input type="checkbox"/> Do you have any difficulties chewing? |
| <input type="checkbox"/> Do you clench your jaw? | <input type="checkbox"/> Do you have any pain in your jaw or face? |
| <input type="checkbox"/> Do your jaws ever feel tired? | <input type="checkbox"/> Do you have frequent headaches? |
| <input type="checkbox"/> Do you wear dentures or partials? | <input type="checkbox"/> Do you clench or grind your teeth? |
| <input type="checkbox"/> Do you gag easily? | <input type="checkbox"/> Have you had any difficult extractions in the past? |
| <input type="checkbox"/> Do you bite your lips or cheeks frequently? | <input type="checkbox"/> Have you had any orthodontic treatment? |
| <input type="checkbox"/> Have you ever had prolonged bleeding due
To extractions? | <input type="checkbox"/> Have you ever received oral hygiene instructions
Regarding the care of your teeth and gums? |
| <input type="checkbox"/> Do you like your smile? | |

Do you ever have pain when your teeth come in Contact with:

- Hot foods or liquids
- Cold foods or liquids
- Sweets/Sours
- Toothbrush/floss

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less then the actually bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

X _____

Signature of Patient (or parent/guardian if minor)