# Kristoff Family Dentistry

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## Adult Clinical History/Family Information (Please complete in ink)

**Patient's Name**_____ M.I.___ Prefer to be called_____

Gender_____ Age_____ Birth Date_____ Driver License #_____

Address_____ City_____ State_____ Zip_____

Home#_____ Cell#_____ Work#_____

Email address_____

Preferred method of contact for appointments _____

Employer_____ Occupation_____

Employer Address_____ City_____ State_____ Zip_____

Social Security Number of Patient **(for accounting purposes only)**_____

**Marital Status:** Single Married Separated Divorced Widowed

**Spouse Name**_____ M.I.___ Prefer to be called_____

Gender_____ Age_____ Birth Date_____

Home#_____ Cell#_____ Work#_____

Employed by_____ Occupation_____

Employer Address_____ City_____ State_____ Zip_____

Social Security Number of Spouse **(for accounting purposes only)**_____

### Primary Dental Insurance

Insurance Company_____ Phone#_____ Group#_____

Subscribers Name_____ Subscribers ID#_____

### Secondary Dental Insurance

Insurance Company_____ Phone#_____ Group#_____

Subscribers Name_____ Subscribers ID#_____

**Responsible Party** (if other than patient/spouse)_____

Is Responsible Party authorized to sign consent on behalf of patient: Yes No

Name_____ SS#_____ Birth Date_____ Relationship_____

Insurance Co_____ Phone#_____ Group#_____ Subscriber ID_____

**Patient's Family Physician**_____ **Phone #**_____

**How did you hear about our office?**_____

**Medical History**

Have you had or do you currently have any of the following?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Rheumatic Fever | ☐ | ☐ | Persistent Headaches | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ | Chemotherapy | ☐ | ☐ |
| Congenital Heart defect | ☐ | ☐ | Human Papilloma Virus HPV | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ | Neck Pains | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Nerve or Brain Disease | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | PRE-MEDICATE | ☐ | ☐ |
| Radiation Treatment | ☐ | ☐ | Sinus Problems | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Migraine | ☐ | ☐ |
| Stroke | ☐ | ☐ | Blood Thinners | ☐ | ☐ |
| Blood Vessel Disease | ☐ | ☐ | Epilepsy | ☐ | ☐ |
| Blood Disorder | ☐ | ☐ | Mental Health Problems | ☐ | ☐ |
| AIDS/HIV Infection | ☐ | ☐ | Bone Disorders | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | Arthritis (any type) | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Artificial Joints | ☐ | ☐ |
| Ulcers | ☐ | ☐ | Sleep Apnea | ☐ | ☐ |
| Herpes (any type)/cold sores | ☐ | ☐ | Ear Disorder | ☐ | ☐ |
| Psoriasis | ☐ | ☐ | Sinus Infection | ☐ | ☐ |
| Cancer | ☐ | ☐ | Swollen Glands | ☐ | ☐ |
| Allergies | ☐ | ☐ | Other_____ | | |

Please comment on any condition you have checked (Date of diagnosis and treatment) _____

_____

_____

Please list all:

**Medications** (Dosage and Frequency) **Including Vitamins** **Allergies**

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Are you under a physician's care at present? If yes, reason_____ |
| ☐ | ☐ | Have you ever been hospitalized or had surgery? If yes, reason_____ |
| ☐ | ☐ | Have you ever had a reaction to local anesthetic? If yes, describe_____ |
| ☐ | ☐ | Are you presently, or have you ever been under the care of a psychiatrist or psychologist? If yes, describe_____ |
| ☐ | ☐ | Are you allergic to any medications? (i.e.: aspirin, penicillin, etc.) If yes, what?_____ |
| ☐ | ☐ | Have you ever had any general anesthesia? When? _____ |
| ☐ | ☐ | Have you ever taken Fen-Phen or Redux? When?_____ |

**FEMALE PATIENTS**

**Yes** **No**

☐ ☐ Have you experienced menopause?

☐ ☐ Has anyone in your family had osteoporosis?

☐ ☐ Is there a possibility that you could be pregnant?

☐ ☐ Do you use oral contraceptives?

☐ ☐ Are you nursing?

**DENTAL HISTORY**

**Yes** **No**

☐ ☐ Do any of your teeth hurt? If yes, ☐ upper right ☐ upper left ☐ lower right ☐ lower left

☐ ☐ Have any wisdom teeth been removed? How many?_____

☐ ☐ Have you ever been required to take antibiotics before visiting the dentist? If yes, why_____

_____

☐ ☐ Have you ever had treatment for periodontal disease (gum disease)? If yes, describe_____

☐ ☐ Have you ever had any previous orthodontic treatment (braces)? If yes, when_____

If yes, doctor's name and address_____

☐ ☐ Have there been any injuries to your mouth or teeth? If yes, describe_____

☐ ☐ Have you ever had any injury in the head and neck area? If yes, describe_____

☐ ☐ Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe_____

_____

☐ ☐ Have you ever had surgery in the head and neck area? If yes, describe_____

☐ ☐ Do you clench or grind your teeth? If yes, ☐while sleeping ☐ under stress ☐ other_____

☐ ☐ Do your jaw muscles ever feel tired or painful? If yes, when_____

☐ ☐ Do you ever notice soreness, tightness, or pain in the muscles around the jaws and face?

If yes, describe_____

☐ ☐ Does it hurt to chew? If yes, where does it hurt?_____

Do you hear clicking (popping) or grating sounds in your jaw joints?

| | Right | Left | Since When | During What Activity |
|---|---|---|---|---|
| ☐ Clicking | ☐ | ☐ | _____ | _____ |
| ☐ Grating | ☐ | ☐ | _____ | _____ |

Did these joint sounds begin gradually or suddenly? ☐ gradually ☐ suddenly

☐ ☐ Was there some specific even that started the joint sounds? If yes, describe_____

☐ ☐ Have you ever experienced difficulty in opening or closing your jaws? If yes, describe_____

_____

**Do you have any of the following habits?**

**Yes** **No**

☐ ☐ Finger/Thumb sucking

☐ ☐ Lip Biting

☐ ☐ Nail Biting

☐ ☐ Gum Chewing

☐ ☐ Ice Chewing

☐ ☐ Smoking or using other tobacco products

We recognize that patients sometimes have specific concerns that may not be addressed in this form. Please feel free to include any other information regarding your clinical history, or any other concerns you may have in the space below.

_____

_____

_____

_____

I have read the above medical and dental information, have reviewed it, and find it accurate. If there are any further changes in my clinical history, I understand that it is my responsibility to inform Dr. Kristoff. I also give permission for Dr. Kristoff to perform a clinical examination and to make recommendations for treatment.

**I have chosen the dental provider: Dr. Kristoff Family Dentistry of my own free will.**

**X_____(please initial)**

I certify that I am covered by _____insurance company and I assign directly to Dr. Kristoff all insurance benefits otherwise payable to me.

I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I acknowledge that I have received a copy of Dr. Kristoff's "Notice of Privacy Act" – HIPPA ACT and Dr. Kristoff's Office Financial Guidelines.

I understand that I am responsible for payment of services rendered and also responsible for paying any fees, co-payment, and deductible that my insurance does not cover.

**I understand I am responsible for any collection agency fees and/or a fee for missed appointments if 2 business days' notice is NOT given.**

**X**_____ _____

(Patient signature) (Date)