kenner dental group
COSMETIC AND RESTORATIVE DENTISTRY
1800 SW 152nd Street, Ste 201, Burien, WA 98166 | (206) 248-1339 | www.kennerdentalgroup.com

Patient Information (CONFIDENTIAL)

Patient Legal Name _____ Birth Date _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ SS# _____ Married ☐ Single ☐

Patient's or Parent's Employer _____ Occupation _____ How Long? _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Person to Contact in Case of Emergency _____ Phone _____

Relationship to Patient _____

Whom May We Thanks for referring You? _____

Primary Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Subscriber ID _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____

Ins Co. Address _____ City _____ State _____ Zip Code _____

Do You Have Secondary Dental Insurance YES ☐ NO ☐ IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Subscriber ID _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____

Ins Co. Address _____ City _____ State _____ Zip Code _____

Over Please

Primary Dental History

Name of Previous Dentist _____ City _____ How Long? _____

When was last dental Check up and/or Teeth Cleaning_____ When was last dental X-ray taken?_____

How often do you... Brush? _____ Floss? _____ See Dentist? _____

Why are you seeking dental care? _____

What would the loss of your Natural Teeth mean to you? _____

Do you have, or have you had any of the following?

	Y	N		Y	N
Head, Neck or Jaw Injuries	☐	☐	Orthodontic Treatment	☐	☐
Sore or Sensitive Teeth	☐	☐	Periodontal Disease (Pyorrhea)	☐	☐
Bleeding Gums	☐	☐	Trouble Open/Close Jaw Joint	☐	☐
Grind or Clench Teeth	☐	☐	Bleeding, Slow Healing after Tooth Extraction	☐	☐
Difficulty in Chewing	☐	☐	Sores in/on Mouth that are Slow to Heal	☐	☐
Anxiety of Dental Treatment	☐	☐	Dissatisfaction with Appearance	☐	☐

Are you happy with your smile? ☐ Y or ☐ N

If not, what would you like to change? _____

_____

_____

Rate your smile

Not Happy 1 2 3 4 5 6 7 8 9 10 Very Happy Wouldn't change a thing

Are you interested in Botox or Derma Filler ☐ Y or ☐ N

Do you have a history of Botox or Derma fill treatment ☐ Y or ☐ N

If yes, explain _____

_____

_____

Do you have any questions regarding dental treatment or procedures that you would like more information on?

☐ Y or ☐ N

If yes, explain _____

_____

_____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Y	N
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operations or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medications(s) are you taking?

_____
_____
_____
_____
_____
_____
_____

	Y	N
4. Are you aware of a change in your general health in the past year?	☐	☐
5. Are you aware of any recent weight changes?	☐	☐
6. Are you often thirsty?	☐	☐
7. Do you urinate more than 6 times a day?	☐	☐
8. Are you often exhausted and fatigued?	☐	☐
9. Do you have frequent headaches?	☐	☐
10. Are you generally a nervous person?	☐	☐
11. Are you often unhappy or depressed?	☐	☐

	Y	N
12. Do you use tobacco?	☐	☐

How many packs per day? _____
How many years have you been smoking? _____

13. Are you allergic to or have you had any reactions to:

	Y	N
Aspirin or Ibuprofen	☐	☐
Penicillin	☐	☐
Erythromycin	☐	☐
Codeine	☐	☐
Sulfa Drugs	☐	☐
Sedatives or Sleeping Pills (barbiturates)	☐	☐
Local Anesthetics (e.g. novocaine)	☐	☐
Animal protein food allergies	☐	☐
Other _____	☐	☐

	Y	N
14. Has your physician requested that you pre-medicate with antibiotics before visiting the dentist?	☐	☐

If Yes, for what condition? _____
What antibiotics are you taking? _____

15. Women only. Are you:

	Y	N
a) Pregnant or think you may be pregnant?	☐	☐
b) Taking birth control pills or other hormones	☐	☐
c) Presently in menopause ("change of life")?	☐	☐
d) Past Menopause?	☐	☐

16. Do you have, or have you had any of the following?

	Y	N
Hepatitis/Jaundice	☐	☐
Epilepsy/Convulsions	☐	☐
Arthritis	☐	☐
Venereal Disease	☐	☐
Scarlet Fever	☐	☐
Rheumatic Fever	☐	☐
Prolong Bleeding due to Slight Cut	☐	☐
Kidney Disease	☐	☐
Anemia	☐	☐
Diabetes	☐	☐
Stomach Troubles/Ulcers	☐	☐
Liver Disease	☐	☐
Tuberculosis	☐	☐
Emphysema	☐	☐
Respiratory Problems	☐	☐
Asthma	☐	☐
Thyroid Problems	☐	☐
Heart Disease	☐	☐
Heart Murmur	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Cardiac Pacemaker	☐	☐
Angina	☐	☐
Chest Pains on Mild Exertion	☐	☐
Stroke	☐	☐
Cancer	☐	☐
Radiation Therapy	☐	☐
Swollen Ankles	☐	☐
Hives, Skin Rash, Hay Fever	☐	☐
Emotional Problems / Tension	☐	☐
Psychiatric Treatment	☐	☐
Glaucoma	☐	☐
AIDS or HIV Infection	☐	☐
Joint Replacement/Implant	☐	☐
Osteoporosis	☐	☐

Other _____
_____
_____

Please explain fully any **YES** answers above.

_____
_____
_____
_____
_____
_____
_____
_____

IF THERE ARE ANY CHANGES IN MY MEDICAL HISTORY, I WILL NOTIFY THE DENTIST.

IN CONSIDERATION OF THE SERVICES PROVIDED TO ME BY THE KENNER DENTAL GROUP, I AM OBLIGATED TO PAY ANY INCURRED FEES IN ACCORDANCE WITH THEIR CREDIT TERMS AND POLICIES.

Date _____ Patient's Signature _____

If patient is a minor, guardian or parent must sign