kb dental
KRISTEN BALUTOWICZ DDS

PATIENT REGISTRATION

Patient Last Name_____**First**_____**Middle Initial**_____

How do you wish to be addressed? _____Date of Birth_____

Address_____City_____State_____Zip_____

Telephone (Mobile)_____ (Home)_____

Email Address _____Patient's Soc. Sec. No._____

☐ Single ☐ Married ☐ Divorced ☐ Male ☐ Female

Full-Time Student? ☐ yes ☐ no School_____

PRIMARY INSURANCE INFORMATION- DENTAL

Last Name_____First_____Initial_____DOB_____

Address_____City_____State_____Zip_____

Telephone (Home)_____(Work)_____(Mobile)_____

Email Address_____

Employer_____Occupation_____

Soc. Sec. No._____

Dental Ins. Co. _____and phone #_____

Group #_____Contract #_____

SECONDARY INSURANCE INFORMATION- DENTAL

Last Name_____First_____Initial_____DOB_____

Address_____City_____State_____Zip_____

Telephone (Home)_____(Work)_____(Mobile)_____

Email Address_____

Employer_____Occupation_____

Soc. Sec. No._____

Dental Ins. Co. _____and phone#_____

Group #_____Contract #_____

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NEAREST RELATIVE / EMERGENCY CONTACT

Last Name_____First_____Initial_____

Address_____City_____State_____Zip_____

Email_____

Telephone (Home)_____(Work)_____(Mobile)_____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. I agree to abide by the company appointment cancelation policy. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

SIGNATURE_____DATE_____

THANK YOU FOR CHOOSING OUR PRACTICE.

We are excited to welcome you to our dental family.

How did you hear about our practice? Whom may we thank for your referral? _____

_____

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DENTAL AND MEDICAL HEALTH HISTORY

PATIENTS LAST NAME_____FIRST_____INITIAL___

Reason for today's visit _____Date of last dental visit_____

Former dentist _____ _____Date of last dental x-rays_____

Any current dental concerns? _____

DENTAL HISTORY

Gum and Bone

Do your gums bleed or are they painful when brushing or flossing? ☐ YES ☐ NO
Have you been treated for gum disease or told you have lost bone around your teeth? ☐ YES ☐ NO
Have you ever noticed an unpleasant taste or odor in your mouth? ☐ YES ☐ NO
Is there anyone with a history of periodontal disease in your family? ☐ YES ☐ NO
Have you ever experienced gum recession? ☐ YES ☐ NO
Have you ever had teeth become loose on their own? Difficulty eating an apple? ☐ YES ☐ NO
Have you ever had burning or painful sensations in your mouth unrelated to teeth? ☐ YES ☐ NO

Tooth Structure

Have you had any cavities in the last 3 years? ☐ YES ☐ NO
Does the amount of saliva in your mouth seem too little? Difficulty swallowing food? ☐ YES ☐ NO
Do you feel or notice any pitting or craters on the biting surface of your teeth? ☐ YES ☐ NO
Are any teeth sensitive to hot, cold, biting, sweets? Avoid any areas while brushing? ☐ YES ☐ NO
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ☐ YES ☐ NO
Do you frequently get food caught between any teeth? ☐ YES ☐ NO

Bite and Jaw Joint

Do you have any problems with your jaw joint? (pain, sounds, popping, locking, etc.) ☐ YES ☐ NO
Do you feel your jaw is being pushed back when you bite together? ☐ YES ☐ NO
Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, protein bars, etc? ☐ YES ☐ NO
Are your teeth becoming more crooked or overlapped? ☐ YES ☐ NO
Are your teeth developing spaces or becoming looser? ☐ YES ☐ NO
Do you place your tongue between your teeth or close on your tongue? ☐ YES ☐ NO
Do you chew ice, bite your nails, use your teeth to hold objects or any other oral habits? ☐ YES ☐ NO
Do you clench your teeth in the daytime or make them sore? ☐ YES ☐ NO
Do you have any sleep problems? Wake up with headaches? Awareness of your teeth? ☐ YES ☐ NO
Do you wear, or have you ever worn a bite appliance? ☐ YES ☐ NO

Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change? ☐ YES ☐ NO
Have you ever whitened your teeth? ☐ YES ☐ NO
Have you ever felt uncomfortable or self-conscious about the appearance of your teeth? ☐ YES ☐ NO
Have you been disappointed with the appearance of previous dental work? ☐ YES ☐ NO

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MEDICAL HISTORY

Physician's name _____Date of last visit _____

Physician's address _____

Have you had any serious illnesses or operations ☐ yes ☐ no

If yes, please describe _____

Have you ever had a blood transfusion ☐ yes ☐ no

If yes, give approximate dates _____

(Women) Are you pregnant? ☐ yes ☐ no Due date _____ Nursing? ☐ yes ☐ no

Taking birth control pills? ☐ yes ☐ no

Please check conditions that apply to you:

☐Abnormal Bleeding	☐Epilepsy	☐Pacemaker
☐Allergies	☐Fainting	☐Radiation Treatment
☐Anemia	☐Glaucoma	☐Rheumatic fever
☐Arthritis/Rheumatism	☐Headaches	☐Scarlet fever
☐Artificial joints	☐Heart problems	☐Shortness of breath
☐Asthma	☐Hepatitis Type___	☐Stroke
☐Blood disease, clotting	☐Herpes	☐Swelling of feet or ankles
Disorders	☐High Blood Pressure	☐Thyroid problems
☐Cancer	☐Kidney disease	☐Tuberculosis
☐Chemotherapy	☐Liver disease	☐Ulcer
☐Cough	☐Low blood pressure	☐Weight loss, unexplained
☐Diabetes	☐Mitral Valve prolapse	
☐Emphysema		

Are you currently under the care of a physician? _____

Allergy to Penicillin, Aspirin, Other Drugs or Latex? Specify: _____

List any medications you are currently taking:

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE_____DATE_____

REVIEWED BY _____DATE_____