

Kelly S. Kennan, D.D.S., P.C.

1820 Sweetbay Dr, Suite #104, Salisbury, MD 21804

Phone 410-742-4339 Fax 410-742-4388

Welcome! 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 of your dental healthcare 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.

| | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------|
| Today's date: | | | | |
| <i>About you (Confidential)</i> | | | | |
| Patient's last name: | | <input type="checkbox"/> Mr. <input type="checkbox"/> Miss | | |
| First: | | <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. | | |
| Middle: | | <input type="checkbox"/> Mrs. | | |
| Marital status (circle one) Minor/ Single/ Married/ Divorced/ Widowed/ Separated | | | | |
| Soc. Sec #: | Email: | Birth date: / / | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street address: | | Home phone: | Cell phone: | |
| City: | State: | ZIP Code: | Driver's License #: | |
| Occupation: | Employer: | Work Phone: | | |
| Employer Address: | | | | |
| If student, name of school/college: | | City: | State: | ZIP Code: |
| Spouse or Parent's Name: | | Spouse or Parent's Employer: | | |
| Work Phone: | | Whom May We Thank for Referring You: | | |
| <i>Account Information</i> | | | | |
| Person Ultimately Responsible for Bill: | | | Phone: | |
| Address (if different): | | | Birth Date: / / | |
| Soc. Sec. #: | Driver's License #: | Work Phone: | | |
| Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No | Employer: | Employer Address: | | |
| City: | State: | ZIP Code: | | |
| For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is expected at each appointment. | | <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> VISA <input type="checkbox"/> Master Card <input type="checkbox"/> Care Credit <input type="checkbox"/> I wish to discuss the office's payment policy | | |
| <i>Insurance Information</i> | | | | |
| Primary Dental Insurance Co. Name: | | Address: | | |
| City: | State: | ZIP Code: | Phone: | |
| Insured's Soc. Sec #: | Group #: | Subscriber ID #: | | |
| Subscriber's Name: | Birth Date: / / | Relationship to Patient: | | |
| Insured's Employer: | | | | |
| Secondary Insurance Co. Name (if applicable): | | Address: | | |
| City: | State: | ZIP Code: | Phone: | |
| Insured's Soc. Sec. #: | Group #: | Subscriber ID #: | | |
| Subscriber's Name: | Birth Date: / / | Relationship to Patient: | | |
| Insured's Employer: | | | | |
| <i>In the Event of an Emergency</i> | | | | |
| Who should we contact? | | Relation: | Phone #: | |
| Who is your medical doctor? | | Doctor's Phone: | | |

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Any health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

| | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Are you under a physician's care now? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | Explain: |
| Have you ever been hospitalized or had a major operation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | Explain: |
| Have you ever had a serious head or neck injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | Explain: |
| Are you taking any medications, pills, or drugs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | Explain: |
| Do you take, or have you taken, Phen-Fen or Redux? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | Explain: |
| Are you on a special diet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | Explain: |
| Do you use tobacco? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | Explain: |
| Do you use controlled substances? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | Explain: |
| Are you... | Pregnant/Trying to get pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No | Taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you allergic to any of the following? <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Metal <input type="checkbox"/> Latex <input type="checkbox"/> Local Anesthetics <input type="checkbox"/> Other | | | | |
| Do you have, or have you had, any of the following? | | | | |
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Diseases | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/ Failure | <input type="checkbox"/> LBP | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/ Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruises Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> HBP | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had a serious illness not listed above? Yes No N/A _____

Comments: _____

*Condition may require medication

N/A- Not Answered

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Parent/Guardian _____

Date _____