

Patient Information Form

First Name: _____ Middle: _____ Last: _____

Social Security #: _____ Date of Birth: _____ Marital Status: Single Married Divorced Separated Widowed

Home#: _____ Work: _____ Cell: _____ Email: _____

Physical Home Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____
(If different from physical address)

Employer Company Name: _____ Your Supervisors Name: _____

Employer Address: _____ Your Job Title: _____

Nearest Relative or Friend **not living with you**: _____ Phone: _____ Relation: _____

Whom may we contact in the case of an emergency? _____ Phone: _____ Relation: _____

INSURANCE INFORMATION

Is Patient a full time student? _____ If yes name and location of school: _____

Name of insured/Subscriber: _____ Relationship to patient: _____

Birth date of insured/ Subscriber: _____ SS# of insured/Subscriber: _____

Address of Insured: _____ Phone: _____

Name of Employer for Subscriber: _____ Wk Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company Name: _____ Phone: _____

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

Group/Account #: _____ Insurance card ID number: _____ Annual Maximum\$ _____ Deductible\$ _____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Kai Funke DDS. I agree to be responsible for all charges for dental services and material not paid by my dental benefit plan. I consent to the use and disclosure of my protected health information to carry out payment activities in connection with my dental claims.

Signature: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? _____ YES _____ NO (if yes ask for another form to fill out)

Who referred you to our office? _____
Please provide name, we would love to send a thank you card

I will be paying today by Cash: _____ Credit Card: _____ Debit Card _____ (Visa /MC/Discover/Amex and the card must be in your name)

Sorry but checks are **NOT** accepted on the first visit (we do accept debit cards); if you have insurance you may still have a co-pay today.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have completed all of the above answers and I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I also understand that payment is expected the same day services are rendered unless prior financial arrangements have been made with the office manager. If you have insurance we will gladly help you process your claims but we require that you pay your estimated portion the day services are rendered.

Signature of Patient

Print Name

Date

MEDICAL HISTORY

Date _____ SS/HIC/Patient ID# _____

Patient Name _____ Date of Birth _____

Check (✓) if you have or have had problems with any of the following:

| | | | | | |
|--|--|-----------------------|--|---------------------------------|--|
| AIDS/HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Endocarditis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fibromyalgia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma or Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Claustrophobia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Contact Lenses | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| COPD | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles or mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | Nasal Obstruction | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs. Check (✓) the medications you are presently taking, medications you have taken in the past, or medications you have had an adverse reaction to:

| | Presently Taking | Taken in the Past | History of Reaction | | Presently Taking | Taken in the Past | History of Reaction | | Presently Taking | Taken in the Past | History of Reaction |
|--------------------------------------|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
| Anesthetics, Locally Injected | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone or Other Steroids | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insulin or Diabetes Medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anesthetics, General | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Coumadin, Heparin, Warfarin or other blood thinners | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives or Tranquilizers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Antacids | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dilantin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleeping Pills (Barbiturates) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anti-anxiety Medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diuretics (water pills) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Medication such as Synthroid, Levoxyl or Levothyroxine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anti-depressants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fen-phen (Ionimin, adipex, Fastin, phentermine, Pondimin, fenfluramine, Redux, dexfenfluramine) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tylenol (Acetomeniphen) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Antihistamines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Medications such as Digoxin, Nitroglycerin or Digitalis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adverse reaction to any other medication or drug | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Daily Aspirin Regimen | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ibuprofen (Motrin) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Please specify _____ | | | |
| Birth Control Pills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | _____ | | | |
| Blood Pressure Medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | _____ | | | |
| Cholesterol Medication | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | _____ | | | |
| Codeine, Demerol or Other Analgesics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | _____ | | | |

List the other medications you are currently taking and what condition you are taking them for. Include vitamins, supplements, herbs and over the counter medications.

| Medication | Condition | Prescribing Doctor |
|------------|-----------|--------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Pharmacy Name _____ Phone () _____

Women: Are you pregnant? Yes No Nursing? Yes No Have you had any serious illnesses or surgeries? Yes No If yes, describe _____

Do you have any other health needs you should bring to our attention? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

DOCTORS COMMENTS ONLY

SIGNATURE OF DENTIST:

DATE:

DENTAL HISTORY & PATIENT GOALS

Date _____ SS/HIC/Patient ID# _____

Patient Name _____ Date of Birth _____

DENTAL HISTORY

Dental Clinic _____ Dentist's Name _____

Street Address _____ City _____ State _____ Zip _____

Phone () _____ Date of Last Appt _____ Date of Last X-Rays _____

Why did you leave your previous dentist? _____

Check (✓) if you have or have had problems with any of the following:

| | |
|--|---|
| <p>Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sores, blisters, growths on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Biting cheeks or lips <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chewing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Talking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prominent gag reflex <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Snoring <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pyorrhea or trench mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Wisdom teeth extracted <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bite problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Missing teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shifting position of teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tobacco use <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chewing on foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thumb sucking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tongue thrusting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain on brushing teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loose or broken teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loose or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity to hot <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stained teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Grinding or clenching teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaw pain or fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Opening or closing jaw <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|---|

How often do you brush? _____ How often do you floss? _____

How often do you have your teeth cleaned? _____

How often do you change toothbrushes? _____

PATIENT GOALS

What is your goal for dental treatment today? _____

Are you in discomfort today? Yes No

Are you pleased with the appearance of your teeth? Yes No If no, please explain _____

Do you like your smile? Yes No If no, please explain _____

Does dental treatment make you nervous? Yes No If yes, please explain _____

Have you been pleased with your previous dental care? Yes No

Have you ever had a bad experience in a dental office? If so, explain _____

How can we help improve your teeth and smile? _____