Southern Kentucky Smiles
940 US 31-W By Pass Bowling Green, KY 42101
p.270 781 3311 f. 270 842 6465
southernkysmiles@gmail.com
www.southernkysmiles.com

PATIENT INFORMATION

Name _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Patient's or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____

City _____ State _____ Zip _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured _____

Relationship to patient _____

Birthdate _____ SS# _____

Employer _____ Work Phone _____

Address of Employer _____

City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy ID# _____

Insurance Company Address _____

City _____ State _____ Zip _____

SECONDARY DENTAL INSURANCE INFORMATION

If Applicable

Name of Insured _____

Relationship to patient _____

Birthdate _____ SS# _____

Employer _____ Work Phone _____

Address _____

City _____ State _____ Zip _____

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain: _____	☐	☐
Are you taking any medications?	☐	☐
Including non-prescription medicine?	☐	☐
If yes, please explain: _____		
Have you every taken Phen-Fen/Redux?	☐	☐
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐
Are you pregnant or may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Are you allergic to or have you had any reactions to the following?

	Yes	No		Yes	No		Yes	No
Local Anesthetics (Novocaine)	☐	☐	Penicillin or any other Antibiotics	☐	☐	Sulfa Drugs	☐	☐
Barbiturates	☐	☐	Sedatives	☐	☐	Iodine	☐	☐
Aspirin	☐	☐	Any Metals (nickel, mercury, etc.)	☐	☐	Latex Rubber	☐	☐

Other: _____

Have you ever been prescribed a CPAP or BiPAP? Yes ☐ No ☐

Have you ever received Botox injections for cosmetic or therapeutic purposes? Yes ☐ No ☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Respiratory Problems	☐	☐
Rheumatic Fever	☐	☐	Stroke	☐	☐	Fainting/Seizures	☐	☐
Emphysema	☐	☐	Tuberculosis	☐	☐	Thyroid Problem	☐	☐
Asthma	☐	☐	Cancer	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Joint Replacement or Implant	☐	☐	Hepatitis/ Jaundice	☐	☐
Liver Disease	☐	☐	Anemia	☐	☐	Mitral Valve Prolapse	☐	☐
Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Obstructive Sleep Apnea	☐	☐
Kidney Diseases	☐	☐	Stomach Troubles/Ulcers	☐	☐	AIDS or HIV Infection	☐	☐

Have you ever taken Bisphosphonates for bone density disorders (such as: Fosamax, Actonel, Evista, Forteo, ect)?

Yes ☐ No ☐

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____

Date of Last Exam _____

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?	☐	☐	Do you have frequent headaches?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	Do you clench or grind your teeth?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐	Do you bite your lips or cheeks?	☐	☐
Do you feel pain in any of your teeth?	☐	☐	Have you ever had any difficult	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐	extractions in the past?	☐	☐
Have you had any head, neck, or jaw injuries?	☐	☐	Have you ever had any prolonged	☐	☐
Have you ever experienced any of the following			bleeding following extractions?		
problems in your jaw?	☐	☐	Have you had any orthodontic		
Clicking?	☐	☐	treatment?	☐	☐
Pain (Joint, Ear, Side of Face)?	☐	☐	**Does your physician recommend**		
Difficulty in opening or closing?	☐	☐	**antibiotics prior to dental visits?**	☐	☐
Difficulty in chewing?	☐	☐			
Do you like your smile? If no, why not? _____	☐	☐			

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of patient (or parent/guardian if minor) Date

PERIODONTAL RISK ASSESSMENT QUESTIONNAIRE

Name _____ Date of Birth _____

Do you now, or have you ever used the following:

	Amount Per Day	# Years Used	What Year Quit
☐ Tobacco Products			

For Patients with Diabetes:

Is your diabetes under control? ☐ Yes ☐ No

Are you prone to diabetic complications? ☐ Yes ☐ No

How do you monitor your blood sugar? _____

Who is your physician for diabetes? _____

Do you have any risk factors for heart disease or stroke?

☐ Family history of heart disease ☐ Tobacco ☐ Obesity

☐ High cholesterol ☐ High blood pressure

Are you taking or have you ever taken any of the following medication:

☐ Anti-seizure medications (such as Dilantin, Tegretol, Phenobarbital, etc.)

If you answered yes, are you still taking anti-seizure medication? ☐ Yes ☐ No

Other Medications: _____

☐ Calcium Channel Blocker blood pressure medication (such as Procardia, Cardizem, Norvasc, Verapamil.)

☐ Immunosuppressant therapy (such as Prednisone, Azathioprine, Cyclosporins, Corticosteriods, Asthma-Inhalers, etc.) Other: _____

☐ Estrogen Replacement Therapy/ Hormone Replacement Therapy (such as: Prempro, Premarin, Premphase.)

Is there an immediate family member(s) who currently has or had gum problems in the past? (e.g. your mother, father, or siblings): ☐ Yes ☐ No

The following can adversely affect your gums. Please check all that apply:

☐ Pregnant ☐ Nursing ☐ Menopause

☐ Taking birth control pills ☐ Infrequent care during previous pregnancy

Have you ever noticed any of the following signs of gum diseases?

☐ Bleeding gums during toothbrushing ☐ Pus between the teeth and gums

☐ Red, swollen, or tender gums ☐ Loose or separating teeth

☐ Gums that have pulled away from the teeth ☐ Change in the way your teeth fit together

☐ Persistent bad breath ☐ Food catching between teeth

It is important to keep your teeth for as long as possible? ☐ Yes ☐ Not Really

If you have missing teeth, why have you not had them replaced? _____

Do you like the appearance of your smile? ☐ Yes ☐ No

Do you like the color of your teeth? ☐ Yes ☐ No

Do your teeth keep you from eating any specific food? ☐ Yes ☐ No

Signature _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices of this office.

Patient Name (Please Print) _____

Signature _____ Date _____

Please note: It is your right to refuse to sign this acknowledgement.

Office Use Only:

We tried to obtainwritten acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- ☐ An emergency prevented us from obtaining acknowledgement.
- ☐ A communication barrier prevented us from obtaining acknowledgement.
- ☐ The individual was unwilling to sign.
- ☐ Other: _____

_____