William D Kenfield DDS LLC

Patient Information

Patient Name____ Phone# (_____) __________ Cell# (   )___________
Last First MI

Address ____________________________________ City _______________________ State ____ Zip ________________

Social Security #______________________Birth Date_________________ Male [] Female [] Marital Status__________

Parent/Guardian/Responsible Party Information

Name ____ E-mail ____

Address_____________________________________City___________________________State_____Zip_______________

Employer____Phone# (____) _____________________

Insurance Company Name____ Phone# (____) _____________________

Medical History

Are you under a physician's care? [] No [] Yes explain____

Have you ever been hospitalized? [] No [] Yes explain____

Have you ever had a major operation? [] No [] Yes explain____

Have you ever had a serious head/neck injury? [] No [] Yes explain____

Have you taken bisphosphonates including Actonel, Fosamax, Boniva, Skelid, Zometa, Aredia, Didronel, or Clodronate? [] No [] Yes list____

Are you on a special diet? [] No [] Yes explain____

Do you use tobacco? [] No [] Yes type____

Are you taking any medicines, drugs, pills, or herbal supplements including garlic, ginseng, genko, feverfew, vitamin E or fish oil? [] No [] Yes list____

Are you allergic to any of the following? Please check the box below

[] Penicillin [] Codeine [] Latex [] Aspirin [] Local Anesthetics [] Acrylic [] Metal [] Other__________________

Women, are you:

Pregnant or trying to get pregnant? [] Yes [] No Taking birth control [] Yes [] No Nursing [] Yes [] No

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

AIDS/HIV	[] Yes [] No	Bisphosphonates	[] Yes [] No	Cortisone Medication	[] Yes [] No
Allergies to Meds	[] Yes [] No	Blood Disease	[] Yes [] No	Currently Nursing	[] Yes [] No
Allergies	[] Yes [] No	Bloody Sputum	[] Yes [] No	Diabetes	[] Yes [] No
Alzheimer's Disease	[] Yes [] No	Breathing Problems	[] Yes [] No	Drug/Alcohol Abuse	[] Yes [] No
Anemia	[] Yes [] No	Bruise Easily	[] Yes [] No	Emphysema	[] Yes [] No
Anesthetic Allergy	[] Yes [] No	Cancer	[] Yes [] No	Epilepsy/Seizures	[] Yes [] No
Angina/Chest Pain	[] Yes [] No	Chemotherapy	[] Yes [] No	Excessive Bleeding	[] Yes [] No
Arthritis	[] Yes [] No	Codeine Allergy	[] Yes [] No	Excessive Thirst	[] Yes [] No
Artificial Joint	[] Yes [] No	Cold Sores	[] Yes [] No	Fainting	[] Yes [] No
Asthma	[] Yes [] No	Congenital Heart		Frequent Cough	[] Yes [] No
Birth Control	[] Yes [] No	Disorder	[] Yes [] No	Glaucoma	[] Yes [] No

Head Injury	[] Yes [] No	Leukemia	[] Yes [] No	Sinus Problems	[] Yes [] No
Heart Attack	[] Yes [] No	Liver Disease	[] Yes [] No	Stomach/Intestinal Problems	[] Yes [] No
Heart Disease	[] Yes [] No	Mitral Valve Prolapse	[] Yes [] No	Stroke	[] Yes [] No
Heart Murmur	[] Yes [] No	Pacemaker	[] Yes [] No	Thyroid Disease	[] Yes [] No
Heart Surgery	[] Yes [] No	Penicillin Allergy	[] Yes [] No	TMD/TMJ	[] Yes [] No
Heart Valve Replaced	[] Yes [] No	Pregnancy	[] Yes [] No	Transfusion	[] Yes [] No
Hemophilia	[] Yes [] No	PRE-MED	[] Yes [] No	Tuberculosis	[] Yes [] No
Hepatitis	[] Yes [] No	Psychiatric Care	[] Yes [] No	Tumors/Growths	[] Yes [] No
High Blood Pressure	[] Yes [] No	Radiation Treatment	[] Yes [] No	Ulcers	[] Yes [] No
Illness Not Listed	[] Yes [] No	Renal Dialysis	[] Yes [] No	Venereal Disease	[] Yes [] No
Irregular Heart Beat	[] Yes [] No	Rheumatic Fever	[] Yes [] No		
Kidney Disease	[] Yes [] No	Recent Weight Loss	[] Yes [] No		
Latex Allergy	[] Yes [] No	Respiratory Problems	[] Yes [] No		

Have you had any serious illness not listed above? [] No [] Yes please explain____
____

Dental History

Do you have a specific dental problem? Please describe____
____ [] Yes [] No
Do you have dental examinations on a routine basis? Last visit____________________________________ [] Yes [] No
Do you think that you have cavities or gum disease? ____ [] Yes [] No
Do your gums bleed? ____ [] Yes [] No
Have you ever had periodontal (gum disease) treatment? ____[] Yes [] No
Do you ever have popping, clicking, or discomfort in your jaw joint? Do you brux or grind your teeth? ________ [] Yes [] No
Do you have pain near your ears or difficulty opening or closing your mouth_________________________ [] Yes [] No
Do any of your teeth hurt when you bite?____[] Yes [] No
Do you like your smile? If no, why? ____ [] Yes [] No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status, or if my medicines change, I will inform the dentist or his staff at my next appointment. I understand that payment is my obligation regardless of insurance or any third party involvement.

____ Date_________________ Relationship to Patient ___________________
Signature of Patient, Parent, or Guardian
2nd year signature_______________________________ Date_________________ Relationship to Patient ___________________
3rd year signature_______________________________Date _________________ Relationship to Patient ___________________

Referral Information

Whom may we thank for referring you to our office?

[] Another Patient [] Yellow Pages [] Radio Advertisement [] Web Site [] Other
Name of person referring you to our practice ____

Who, if anyone (spouse, family member etc.), may we discuss your treatment with or release information to?
____