

email :

WELCOME
DAVID KEMLER D.D.S.
5954 BROOK ROAD
RICHMOND, VA 23227
(804) 266-7976

1. About you

Today's Date ____/____/____

Patient's Name: _____
Last First MI

What do you prefer to be called? _____ M F BirthDate ____/____/____

Mailing Address: _____
Work Phone # _____

City State Zip Cell Phone # _____

Home Phone: _____ Ext: _____

2. In Event of Emergency

Employer: _____

Whom should we contact? _____

Employer's Address: _____

Relation _____

Occupation: _____

Home Phone # _____
Work Phone # _____

Status: Minor Single Married Divorced Widowed

Spouse's Name: _____

Do you have any children? _____ If so, how many? _____

3. Insurance Information

Primary Dental Insurance

Company Name: _____
Address: _____

Please indicate if you have a secondary insurance plan Y / N (Circle)

City State Zip

Phone #: (____) _____

Secondary insurance will be filed by and paid to the patient. However, in order to do so our front desk must know prior to services being performed so the necessary paperwork can be prepared and given to the patient.

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured Name: _____

Relation: _____ Insured Date of Birth: ____/____/____

Insured Employer: _____

4. Dental Information

Reason for today's visit: Exam Emergency Consultation

Whom may we thank for mentioning us?

Are you in pain? No Yes How Long? _____

Discomfort, clicking or popping of jaw Lost/Broken Fillings Stained Teeth

Red, swollen or bleeding gums Teeth Grinding Locking jaw

Sensitive tooth, teeth or gums Ringing in Ears Bad Breath

Blisters / Sores in and around the mouth Broken / Chipped tooth

Other: _____

Do you require pre-medication? Yes No Don't Know

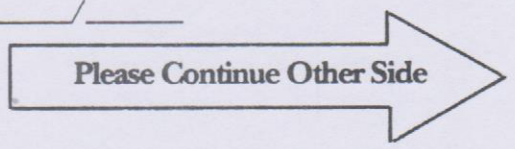
Previous Dentist: _____ (____) _____
Name Phone #

Last Dental Exam ____/____/____ Last Dental X-Rays ____/____/____

Times a day you brush? _____ Times a week you floss? _____

What type of toothbrush do you use? Soft Medium Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)



5. Medical History

Are you taking any medications, please list:

Do you have or have you had any of the following diseases, medical conditions, or procedures?

- | | | |
|-------------------------------|-------------------------------|------------------------------------|
| Y N Heart Attack / Stroke | Y N Thyroid Problems | Y N Cancer / Tumors |
| Y N Heart Surgery / Pacemaker | Y N Kidney Problems | Y N Shingles |
| Y N Heart Murmur | Y N Liver Problems | Y N Hepatitis |
| Y N Rheumatic Fever | Y N Respiratory Problems | Y N HIV / AIDS / ARCY |
| Y N Mitral Valve Prolapse | Y N Sinus Problems | Y N Arthritis / Rheumatism |
| Y N Artificial Valves | Y N Stomach Problems / Ulcers | Y N Artificial Bones / Joints |
| Y N Heart Disease | Y N Psychiatric Problems | Y N Emphysema |
| Y N Congenital Heart Defect | Y N Venereal Disease | Y N Fainting / Seizures / Epilepsy |
| Y N Chest Pains | Y N Alcohol / Drug Abuse | Y N Severe / Frequent Headaches |
| Y N Scarlet Fever | Y N Tuberculosis | Y N Frequent Neck Pain |
| Y N Nervousness | Y N Jaw Problems TMJ/TMD | Y N Back Problems |
| Y N Cosmetic Surgery | Y N Difficulty Breathing | Y N High / Low Blood Pressure |
| Y N X-Ray or Cobalt Treatment | Y N Diabetes / Hypoglycemia | Y N Bleeding Problems |
| Y N Chemotherapy | Y N Leukemia | Y N Glaucoma |
| Y N Asthma | Y N Anemia | |

Who is your medical doctor? _____

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? Latex Penicillin / Amoxicillin Tetracycline
 Aspirin Dental Anesthetics

Other Allergies: _____

Do you use tobacco? No Yes How used? _____ How much? _____ How long? _____

Please rate your general health from 1 - 10: _____ Do you wear contact lenses? Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? No Yes How long? _____ Are you nursing? Yes No

- ◆ We invite you to discuss with us any questions regarding our services. The best Dental Health services are based on a friendly, mutual understanding between provider and patient.
- ◆ Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- ◆ I authorize the staff to perform any necessary services during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ◆ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

◆ Signature: _____ Date: ____/____/____