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: _____

Employer : _____

Employer's Address: _____

Occupation : _____

Status : ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name : _____

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

2. In Event of Emergency

Whom should we contact ?

_____

Relation _____

Home Phone # _____

Work Phone # _____

3. Insurance Information

Primary Dental Insurance

Company Name : _____

Address : _____
City State Zip

Phone # : (____)_____

Insured's SS# : _____

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

Insured Name : _____

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

Insured Employer : _____

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

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.

4. Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

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)

Whom may we thank for mentioning us ?

_____

_____

Please Continue Other Side

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

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- 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 ____/ ____/____