



WELCOME TO KELLY JORN COOK, DDS, PC

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

TELL US ABOUT YOURSELF – PATIENT INFORMATION

Today's Date: _____
 Name: _____
 I prefer to be called: _____ Female Male
 Date of Birth: ___/___/___ Social Security No.: _____
 Single Married Divorced Widowed Separated
 Home Address: _____

 CITY STATE ZIP

Home Phone Number: () _____ Cell Phone Number: () _____
 Work Phone Number: () _____ Employer: _____
 Occupation: _____ where and when is the best time to reach you? _____
 Email Address: _____ Spouse's Name: _____
 Other family members seen by us: _____
 Whom can we thank for referring you? _____

ACCOUNT INFORMATION – PERSON ULTIMATELY RESPONSIBLE FOR THE ACCOUNT

Name: _____ Relation: _____
 Billing Address: _____

 CITY STATE ZIP
 Social Security No.: _____ Home Phone Number: () _____
 Employer: _____ Work Phone Number: () _____

PRIMARY DENTAL INSURANCE

Insurance Company Name: _____
 Claims Address: _____ Phone Number: () _____
 Subscriber's Name: _____ Date of Birth: ___/___/___ Subscriber ID: _____
 Group Number: _____ Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Company Name: _____
 Claims Address: _____ Phone Number: () _____
 Subscriber's Name: _____ Date of Birth: ___/___/___ Subscriber ID: _____
 Group Number: _____ Employer: _____

EMERGENCY CONTACT INFORMATION

Who should we contact in case of emergency? _____ Relation: _____

EMERGENCY CONTACT INFORMATION CONTINUED

Home Phone Number: () _____ Cell Phone Number: () _____

Work Phone Number: () _____ who is your medical doctor? _____

What is your MD's Phone Number? () _____

MEDICAL/DENTAL INFORMATION

What brings you to the dentist today? _____

Are you in pain? No Yes If yes, for how long? _____ Do you require pre-medication? No Yes

Have you ever had a problem with previous dental work? No Yes

Please check any of the following problems:

- Discomfort, clicking or popping jaw
- Sensitive Teeth
- Teeth Grinding
- Red, swollen or bleeding gums
- Broken/Chipped Teeth
- Bad Breath
- Lost/Broken Fillings
- Stained/Discolored Teeth

Other: _____

When was you last dental exam? _____ Last dental x-rays? _____

Time(s) a day you brush: _____ Time(s) a week you floss: _____ Type of Toothbrush you use: Soft Medium Hard

How would you rate your smile (1-10): _____ how would you like to improve your smile? _____

Are you currently under the care of a physician? No Yes If yes, please explain: _____

Do you smoke or use tobacco in any other form? No Yes Have you ever had any of the following diseases or medical conditions? :

- | | | | |
|-----------------------------|---------------------------|--------------------|---------------------------|
| Y N Heart Attack/Stroke | Y N Kidney Problems | Y N Asthma | Y N Diabetes/Hypoglycemia |
| Y N Heart Surgery | Y N Pacemaker | Y N Hepatitis | Y N Leukemia |
| Y N Heart Murmur | Y N Respiratory Problems | Y N HIV+/AIDS | Y N Arthritis/Rheumatism |
| Y N Heart Disease | Y N Ulcer | Y N Anemia | Y N Frequent Neck Pain |
| Y N Rheumatic Fever | Y N Psychiatric Problems | Y N Emphysema | Y N Severe Headaches |
| Y N Mitral Valve Prolapse | Y N Venereal Disease | Y N Glaucoma | Y N Seizures/Epilepsy |
| Y N Artificial Valves | Y N Tuberculosis TB | Y N Chest Pain | Y N Alcohol/Drug Abuse |
| Y N Artificial Bones/Joints | Y N Scarlet Fever | Y N Fainting | Y N Jaw Problems TMJ/TMD |
| Y N High Blood Pressure | Y N Back Problems | Y N Shingles | |
| Y N Low Blood Pressure | Y N Fever Blister/ Herpes | Y N Chemotherapy | |
| Y N Congenital Heart Defect | Y N Cancer/Tumor | Y N Sinus Problems | |

Please list any other medical condition(s) you have or ever had: _____

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

Other Allergies: _____ Are you taking any over-the-counter or prescription drugs? No Yes

Please list each one: _____ Have you ever taken Phen-fen or Redux? No Yes

Women: Are you taking an oral contraceptive? No Yes Are you pregnant? No Yes Are you nursing? No Yes

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand that payment is due in full at the time of treatment and that all estimates of my patient portion with regards to insurance are estimates only and not a guarantee of payment from my insurance company.

Patient Name: _____ Signature: _____ Date: _____

FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. _____

INITIALS

DATE