Charles Keith
Dentistry

Today's date:_____ E-mail Address: _____

Patient's Name: _____ I prefer to be called: _____ ☐Male ☐Female

Birthdate ___/___/___ Age:_____ Social Security#:_____ ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____Cell#: _____ Work Phone#: _____ Driver's License #: _____

Where & when are best times to reach you? _____ Whom may we thank for referring you? _____

Employer: _____ Address: _____

Spouse: _____

Employer: _____ Address: _____

MEDICAL HISTORY

Do you have a personal physician? ☐Y ☐N

Are you currently under the care of a physician? ☐Yes ☐No

Physician's Name: _____

Please explain: _____

Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

Do you smoke or use tobacco in any form? ☐Yes ☐No
Have you ever taken Phen·Fen, Redux or Pondimin? ☐Yes ☐No
For Women, are you taking birth control pills? ☐Yes ☐No

Date of last visit: _____

Are you pregnant? ☐Unsure? ☐Yes ☐No

Your current physical health is: ☐Good ☐Fair ☐Poor

Week #: _____ Are you nursing? ☐Yes ☐No

Do you or have you experienced the following?

○○ Abnormal Bleeding	○○ Colitis	○○ Hay Fever	○○ Liver Disease	○○ Shingles
○○ Alcohol Abuse	○○ Congenital Heart Defect	○○ Headaches	○○ Low Blood Pressure	○○ Sickle Cell Disease
○○ Anemia	○○ Diabetes	○○ Heart Attack	○○ Lupus	○○ Sinus Problems
○○ Arthritis	○○ Difficulty Breathing	○○ Heart Murmur	○○ Mitral Valve Prolapse	○○ Steroid Therapy
○○ Artificial Bones/Joints	○○ Drug Abuse	○○ Heart Surgery	○○ Pacemaker	○○ Stroke
○○ Artificial Valves	○○ Emphysema	○○ Hemophilia	○○ Persistent Cough	○○ Thyroid Problems
○○ Asthma	○○ Epilepsy	○○ Hepatitis	○○ Psychiatric Problems	○○ Tonsillitis
○○ Blood Transfusion	○○ Ever Hospitalized	○○ Herpes	○○ Radiation Treatment	○○ Tuberculosis (TB)
○○ Cancer	○○ Fainting Spells	○○ High Blood Pressure	○○ Rheumatic Fever	○○ Ulcers
○○ Chemotherapy	○○ Fever Blisters	○○ HIV /AIDS	○○ Scarlet Fever	○○ Venereal Disease
○○ Chicken Pox	○○ Glaucoma	○○ Kidney Problems	○○ Seizures	

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription / over the counter drugs? ☐Yes ☐No If yes, please list each one: _____

_____

Are you allergic to any of the following?

○○ Aspirin	○○ Codeine	○○ Erythromycin	○○ Latex	○○ Sedatives	○○ Tetracycline
○○ Barbiturates	○○ Dental Anesthetics	○○ Jewelry Metals	○○ Penicillin	○○ Sulfa Drugs	○○ Other

Please list anything additional that causes allergic reactions: _____

_____

Patient's Signature: _____ Doctor's Signature: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Charles Keith Dentistry

DENTAL HISTORY

Why have you come to the dentist today?_____

_____

Are you currently in pain? ☐Yes ☐No

Do you require antibiotics before dental treatment? ☐Yes ☐No

Do you floss daily? ☐Yes ☐No Brush daily? ☐Yes ☐No

Type of bristles on your toothbrush? ☐Hard ☐Medium ☐Soft

Do your gums bleed? ☐Yes ☐No Ever Itch? ☐Yes ☐No

Have you ever had periodontal disease? ☐Yes ☐No

Are your teeth sensitive to heat, cold, or anything else?

Do you have mobility in your teeth? ☐Yes ☐No

Do you still have wisdom teeth? ☐Yes ☐No

Previous | Present Dentist:_____ Last Visit Date: _____
(Circle One)

Would you like fresher breath? ☐Yes ☐No Whiter teeth? ☐Yes ☐No

Are you happy with the way your smile looks? ☐Yes ☐No

If not, what would you change? _____

_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Dental Coverage? ☐Yes ☐No

Insurance Co. Name: _____ Phone#: _____ Group# (Plan, Local or Policy#): _____

Insurance Co. Address: _____

Insured's Name: _____ Insured's S.S.#: _____ Insured's D.O.B.: ___/___/___ Relation:_____

Insured's Employer: _____ Employer's Address:

_____

Secondary Dental Insurance Dental Coverage? ☐Yes ☒No

Insurance Co. Name: _____ Phone#: _____ Group# (Plan, Local or Policy#): _____

Insurance Co. Address: _____

Insured's Name: _____ Insured's S.S.#: _____ Insured's D.O.B.: ___/___/___ Relation:_____

Insured's Employer: _____ Employer's Address: _____

PAYMENT POLICY

Our policy is to require payment at the time services are provided.

We attempt to remain informed about our patients insurance plans; however, due to the enormous number of such plans, it is impossible for us to determine the exact benefits which each individual plan might pay; therefore, we rely on you to be knowledgeable about your insurance plan and the coverage and benefits it provides. Please note: By filing a claim on your Insurance, we do not guarantee the insurance coverage or benefits paid, nor can we accept responsibility for any amounts which your insurance company may not pay. Written or verbal estimates given by our office are not a guarantee of payment. Amounts filed on your insurance are your responsibility, if for any reason a claim is not fully paid by your insurance, the remaining unpaid balance will become due from you, and payable at that time. Generally, we allow 30 days for claims to be paid by your insurance company.

Our fees are considered standard with other general dentists in the Mobile area. In giving you the care that you need and deserve, we do attempt to keep your cost to a minimum Emergencies and insurance reimbursement are handled on an individual basis: please feel free to discuss financial matters with the office manager.

I have read and ·understand the payment policy above, and agree to comply accordingly.

I, _____, have received a copy of this office's Notice of Privacy Practices.

SUBMIT FORM