Welcome!

Our goal is to make every patient's visit pleasant and educational. We believe in preventive maintenance; therefore we teach good home oral care so you may enjoy a beautiful smile for a lifetime. The more we know about you, the better we can assist you. Thank you for your cooperation.

William H. Kingery, DDS
Mary E. Kingery, DDS

2554 Lewisville-Clemmons Rd
Clemmons, NC 27012
336.766.0511 (phone)
336.766.7390 (fax)
kingerysmiles.com

About you

Name _____ Birthdate _____
Last First Middle

SS# _____ Driver's License# _____

Home address _____
Street/Apt.Condo City State Zip

Email address _____

Marital status (circle): Single Married Divorced Separated Widowed

Home# _____ Pager/cell# _____ Work# _____

Employer _____ Employer's address _____
Street City State Zip

When/Where is the best time to reach you? _____

Whom may we thank for referring you? _____

In case of emergency, please contact _____

Spouse information

Name _____
Last First Middle

Birthdate _____ Home# _____ Work# _____

Employer _____ Employer's address _____

SS# _____ Driver's license# _____

Employer _____ Employer's address _____
Street City State Zip

Responsible party information

Person responsible for account _____
Last First Middle

Billing address _____

Phone# _____ Pager/cell# _____ Work# _____

SS# _____ Relationship to patient _____

Employer _____ Employer's address _____
Street City State Zip

Primary insurance

Insurance co. name _____ Insured's name _____

Insurance co. address _____
Street City State Zip

Phone# _____ Group# _____ Relationship to patient _____

Insured's employer _____ Insured's birthdate _____

More about you

Why are you visiting the dentist today? _____

Y N Have you ever had a serious/difficult problem associated with previous dental work? Please explain _____

Y N Has there been any injury/trauma to the teeth? Please explain _____

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)?

Y N Do you floss daily? How often? _____

Your current physical health is (circle): Good Fair Poor

Physician _____ Phone# _____ Last visit date _____

Y N Do you smoke/use tobacco in any form? Y N Do you use alcohol? Y N Do you use cocaine/other drugs?

Y N Have you ever taken Fen-Phen/Redux?

Please list all drugs that you are currently taking _____

Are you/have you ever had an allergic reaction to:

Y N Aspirin	Y N Codeine	Y N Penicillin/other antibiotics	Y N Other _____
Y N Barbiturates/Sedatives	Y N Local anesthetics	Y N Sulfa drugs	_____

Do you have/have you ever had the following:

Y N Fainting spells/seizure	Y N Heart attack	Y N Low /High blood pressure	Y N Stroke
Y N Heart trouble	Y N Heart surgery	Y N Lung/breathing problems	Y N Other _____

If you answered yes to heart attack/heart surgery, please explain _____

Women:

Y N Are you pregnant/do you think you may be pregnant? Y N Do you take birth control pills? Please name _____

Have you experienced any of the following medical conditions?

Y N Abnormal bleeding	Y N Convulsions/epilepsy	Y N HIV+/AIDS	Y N Replacement joints/ implants
Y N Anemia	Y N Diabetes	Y N Hospital stays	
Y N Asthma	Y N Frequent nose bleeds	Y N Kidney/liver problems	Y N Tuberculosis (TB)
Y N Blood transfusions	Y N Handicap/disabilities	Y N Latex allergies	Y N Sleep Apnea
Y N Blood clots	Y N Hearing impairment	Y N Mitral valve prolapse	Y N Other _____
Y N Brain injury	Y N Heart murmur	Y N Operations	_____
Y N Cancer	Y N Hemophilia	Y N Pregnancy	_____
Y N Congenital heart defect	Y N Hepatitis	Y N Rheumatic fever	_____

If yes to any of the above, please explain _____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. I also authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient or guardian Date