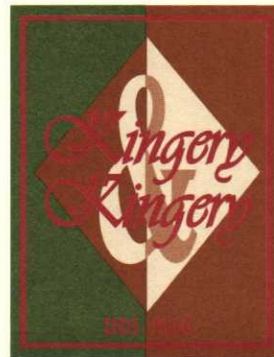


# Welcome!

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.



Warm Hearts, Beautiful Smiles

William H. Kingery, DDS  
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## 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 \_\_\_\_\_  
Street City State Zip  
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, 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 Iodine 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 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 \_\_\_\_\_

## 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/

Y N Anemia Y N Diabetes Y N Hospital stays implants

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 Other \_\_\_\_\_

Y N Blood clots Y N Hearing impairment Y N Mitral valve prolapse \_\_\_\_\_

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 \_\_\_\_\_

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

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 parent or guardian \_\_\_\_\_

Date \_\_\_\_\_