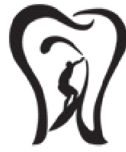
Patient Registration



Kalaheo Dental Group

KalaheoDental.com

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Welcome to Kalaheo Dental Group- *we want your visit to be pleasant and comfortable. Please help us to prepare to serve your treatment needs by completing these forms. If you need assistance, please don't hesitate to ask.*

How did you hear about our office or whom may we thank for referring you?
Facebook_______ Google_______ Yelp_______ Yellowpages_______ Other_____________________

Patient Name: ____ **Preferred:** _________________
First Middle Initial Last

Date of Birth: _________________ **SS#:** ________________________ **Sex:** ____Male ____Female

Status: _____Single _____Married _____Child _____Divorced

Mailing Address: ____
Street/ PO Box City State Zip Code

Home Phone #: ____________________ **Cell #:** ____________________ **Work#:** ____________________

E-mail: ____ (We will not share your e-mail with any 3rd parties)

Preferred method of contact: (Please number in order of preference) ____ Home ____Cell ____Work ____E-mail

Employer: ___________________________________ **Occupation:** _______________________________

May we contact you at work? ___YES ___NO

INSURANCE INFO:

Insurance Carrier: ____________ Subscriber Name: _____________________ Subscriber DOB: __________

Subscriber ID#: _________________ OR Subscriber SS#: _______________ Relationship: _____________
(Self, Spouse, Child)

RESPONSIBLE PARTY: (If not the patient)

Name: ___________________________ Phone: ___________________ Relationship: _______________

EMERGENCY CONTACT:

Name: ___________________________ Phone: ___________________ Relationship: _______________

Dental History & General Oral Health Info

Please answer the following questions to the best of your ability.

1. How can we help you today? ____
2. Are you currently in any pain? Explain,____
3. How is your current dental health? _____ Good _____ Fair _____ Poor
4. Approximately, how many times do you: Brush per day? ___________ Floss per week? __________
5. When was your last dental cleaning? ____
6. When was your last dental visit? What was done?____
7. Are your teeth sensitive to hot, cold or anything else? Explain,_____________________________________
8. **NO YES** Do your gums bleed?
9. **NO YES** Are you missing any teeth?
10. **NO YES** Have you ever had gum treatment?
11. **NO YES** Do you now or have you ever had any pain or discomfort in your jaw joint? (TMJ)
12. **NO YES** Are you under any stress? (New job, moving, relationships, etc...)

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13. **NO YES** Do you like your smile?
14. **NO YES** Would you like to have whiter teeth?

Kalaheo Dental Group offers a wide variety of services to enhance and keep your smile beautiful. Please **circle** any services you would like our friendly staff to discuss with you during your visit.

Implants/Tooth Replacement	**Smile Makeover**	**Bonding**
Veneers/Lumineers	**GLO Whitening**	**Invisalign**

15. **NO YES** Is there anything you would like to change about your smile? Explain,_____________________

____

16. **NO YES** Do we have permission to discuss treatment options to improve your smile and appearance?

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17. **NO YES** Have you ever had any unfavorable dental experiences?
18. **NO YES** Have you ever had a serious or difficult problem with any previous dental work? Explain,_____

____

19. How can we best accommodate you during your dental visit(s)? _________________________________

____

20. **NO YES** Have you been told to take antibiotics before dental treatment? Specify,__________________

____

Medical History & General Health Info

Certain conditions and medications may make it necessary for us to alter our advice regarding your treatment. Please assist us in delivering optimal care by providing the following information:

1. Are you currently taking any medications? If so, please list:____
____
2. Are you currently under the care of a physician? If so, please explain:_______________________________________
3. Have you ever been hospitalized? If so, please explain:____
4. Do you use tobacco in any form? If so, for how long? ____

Do you have a history of: (Circle YES or NO, specify as needed.)

1. **NO YES** Blood pressure or heart problems? ____
2. **NO YES** Mitral valve prolapse or Rheumatic fever? ____
3. **NO YES** Pacemaker, open heart surgery, prosthetic heart valve implant? Stent? ___________________________
4. **NO YES** Joint Replacement, blood transfusions, organ transplant? ______________________________________
5. **NO YES** Tuberculosis or lung problems? Persistent productive coughing? _________________________________
6. **NO YES** Hepatitis, jaundice or liver disease? ____
7. **NO YES** Venereal disease or herpes? ____
8. **NO YES** Acquired Immune Deficiency Syndrome (Aids) or HIV? _______________________________________
9. **NO YES** IV drug use? ____
10. **NO YES** Bleeding or clotting disorder? ____
11. **NO YES** Diabetes, kidney, thyroid problems? ____
12. **NO YES** Ulcers, acid reflux or stomach problems? ____
13. **NO YES** Epilepsy or nervous disorder? ____
14. **NO YES** Asthma, hay fever, sinusitis or other allergies? ____
15. **NO YES** Cancer or tumors? Have you had radiation or chemo therapy? ________________________________
16. **NO YES** Arthritis, fibromyalgia or connective tissue disorder? _______________________________________
17. **NO YES** Head, face or jaw trauma/ injury? ____
18. **NO YES** Do any wounds heal slowly or present complications? _______________________________________
19. **NO YES** History of taking Bisphosphonates? (Fosamax, Zometa, Aredia, Actonel, Boniva, Reclast) ____________
____
20. **NO YES** Taking any blood thinners? (Aspirin, Plavix, Coumadin (Warfin), Pradaxa, Aggrenox, Eliquis, Xarelto)

Allergies: (Circle YES or NO, specify.)

NO YES *Aspirin*	**NO YES** *Codeine*
NO YES *Dental Anesthetics*	**NO YES** *Latex*
NO YES *Erythromycin*	**NO YES** *Metals*
NO YES *Penicillin*	**NO YES** *Amoxicillin*
Other:	

Females: (Circle YES or NO, specify.)

NO YES *Are you taking birth control?*

NO YES *Are you pregnant? If so, how many weeks?* ____ *Due date:* _______

NO YES *Are you nursing?*

Is there any additional health information that we should know? ____
____

I acknowledge that the information I've provided has been given correctly and that it is my responsibility to inform the office and my provider of any changes or updates in my medical history.

_______________________________ _________________________________ ____________________

Patient Name Patient/Guardian Signature Date