

Welcome

*On behalf of Dr. Satbir K. Kahlon and our Dental Team, we are pleased to welcome you to the practice.
Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.
All information will be kept confidential.*

Patient Information

Patient's Name: _____ Email: _____

I prefer to be called _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Social Security # _____ - _____ - _____ Birthdate: ___ / ___ / ___ Age: _____ Sex _____

Marital Status: Single Married Divorced/Separated Widowed

Address: _____ City: _____ Zip: _____

Patients Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Person to contact in case of an emergency: _____ Phone: () _____

Is the patient a student? Full Time Part Time School: _____

Responsible Party's Information

Person Responsible for Account: _____ Relation to Patient _____

Home Phone: () _____ Work Phone: () _____

Mailing Address: _____ City: _____ Zip: _____

Social Security #: _____ - _____ - _____ Drivers License #: _____

Employer: _____ Occupation: _____

Employer's Address: _____ City: _____ Zip: _____

Have you or any member of your family been a patient at this office before? YES NO

If YES, Name: _____

Primary Dental Insurance: YES NO

Secondary Dental Insurance: YES NO

Insured's Name: _____

Insured's Name: _____

SS #: _____ - _____ - _____ DOB: ___/___/___

SS #: _____ - _____ - _____ DOB: ___/___/___

Employer: _____

Employer: _____

Insurance Company/Plan: _____

Insurance Company/Plan: _____

Union/ Group Name: _____

Union/ Group Name: _____

Group or Policy #: _____ Local#: _____

Group or Policy #: _____ Local#: _____

Date Employed: _____

Date Employed: _____

Who may we thank for recommending our office to you? _____

Otherwise, how did you choose our practice? Insurance plan Yellow pages Mailer/AD

Other source: _____

Patient's Dental History

What is the primary reason for your Dental visit? _____

Are you aware of any Dental problems? If so, please explain: _____

Name of your previous Dentist: _____

Date of last Dental Exam/Cleaning: _____ Date of last X-rays: _____

Did your last Dentist recommend any dental treatment for you? If so please describe: _____

Have you had any complications with dental procedures in the past? _____

Please Indicate Past Dental Treatments:

Root Canal Therapy? YES NO
 Extractions/Oral surgery? YES NO
 Orthodontics (braces)? YES NO
 Gum Surgery/ Deep Cleaning? YES NO
 Dental Implants? YES NO
 Treatment for TMJ? YES NO

Are you currently experiencing any of the following?

TMJ/ Jaw Pain? YES NO
 Bleeding/Swollen gums? YES NO
 Grinding/Clenching teeth? YES NO
 Bad Breath? YES NO
 Sensitivity to Sweets/Hot/Cold? YES NO
 Pain when Chewing? YES NO

Are you interested in Cosmetically Improving your Smile? If so please explain: _____

Are you interested in Dental Whitening? YES NO

Patient's Medical History

Name of your Physician: _____ Phone #: _____

Date of your last Medical Exam: _____ Findings: _____

Are you currently undergoing any Medical Treatment? _____

Have you been Hospitalized within the past 5 years? If so, for what reason? _____

List all Medications that you currently take:

Medication	Reason
_____	_____
_____	_____

If you have Allergies to any Medications, please list them: _____

Indicate all conditions that pertain to the patient:

Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you drink Alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Murmur	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, how much? _____	
Mitral Valve Prolapse	<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergies to Penicillin/Antibiotics	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Heart Valve	<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergies to Local Anesthesia	<input type="checkbox"/> YES <input type="checkbox"/> NO
Rheumatic/Scarlet Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	Latex allergy or Sensitivity	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pace maker	<input type="checkbox"/> YES <input type="checkbox"/> NO	Abnormal Bruising/ Bleeding	<input type="checkbox"/> YES <input type="checkbox"/> NO
High or Low Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Anemia	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chest pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Blood Transfusions	<input type="checkbox"/> YES <input type="checkbox"/> NO
Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hemophilia/ Blood Diseases	<input type="checkbox"/> YES <input type="checkbox"/> NO
Fainting or Dizziness	<input type="checkbox"/> YES <input type="checkbox"/> NO	Liver or Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Shortness of Breath	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Joints	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis A, B, C	<input type="checkbox"/> YES <input type="checkbox"/> NO
Head or Neck Radiation	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ulcers or Digestive Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chemotherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures or Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO
HIV/AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma/Emphysema/Respiratory Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cold Sores/ Fever Blisters	<input type="checkbox"/> YES <input type="checkbox"/> NO	Phen-Fen, Pondimin, or Redux	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sinus Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you currently Pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Arthritis/ Rheumatism	<input type="checkbox"/> YES <input type="checkbox"/> NO
If Yes, how many months? _____		Thyroid Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you use Tobacco?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
If Yes, what type and frequency? _____			

All of the information given is accurate to the best of my knowledge. I understand that it is my responsibility to inform Dr. Satbir K. Kahlon of any changes in my Health. Signature: _____ Date: _____

Reviewed by: _____