Wylie Village Dentistry

Family & Cosmetic Dentistry

Dr. Vinay Kumar DDS

Patient Information

Name: ____
First Middle Last Preferred Name

Address: ____

City: ____________________ State: _______ Zip Code: __________

Phone (Home): ____________ (Work): ____________ Ext: ______ Cell Phone: __________

Age:_____ Gender: ☐ Female ☐ Male Family Status: ☐ Single ☐ Married ☐ Widowed

Social Security # : ____________ Date of Birth: __________ DL#: __________

Employer: ____________________ Occupation: __________ Phone # : __________

Email Address: ____

Emergency Contact: ____________________ Relationship: __________

Emergency Contact Numbers: ____

Insurance Subscriber / Responsible Party Information

Name: ____
First Middle Last Preferred Name

Address: ____

City: ____________________ State: _______ Zip Code: __________

Employer: ____________________ Occupation: __________ Phone # : __________

Phone (Home): ____________ (Work): ____________ Ext: ______ Cell Phone: __________

Age:_____ Gender: ☐ Female ☐ Male Family Status: ☐ Single ☐ Married ☐ Widowed

Social Security # ____________ Date of Birth: __________ DL#: __________

Getting To Know You

Whom may we thank for referring you to our practice?

☐ Friend ☐ Relative ☐ Dental Office ☐ Internet ☐ School ☐ Work ☐ Other: ____________

Name: ____
First Middle Last Preferred Name

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Medical Health Questionnaire

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
If yes, for what? ____________________
Physician's Name ____________________ Phone ____________________

Have you or are you taking any medication, drugs or pills? ☐ Yes ☐ No
If yes, please list name and dosage ____________________

Are you aware of having an allergic (or adverse) reaction to any medication or substance? ☐ Yes ☐ No
If yes, please list: ____________________
Have you been a patient in the hospital during the past five years? ____________________

Indicate which of the following you have had, or have at present. Check "yes" or "no" to each item.

Condition	Yes	No
Heart (surgery, disease, attack)	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Diet (Special/Restriction)	☐ Yes	☐ No
Artificial Joints (hip,knee)	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No
Hepatitis A/B	☐ Yes	☐ No
A.I.D.S.	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Yellow Jaundice	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No
Nervous/Anxious	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No
Latex Sensitivity	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Tumors	☐ Yes	☐ No
Veneral Disease	☐ Yes	☐ No
H.I.V. Positive	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Neurological Disorders	☐ Yes	☐ No
Fainting or Dizzy Spells	☐ Yes	☐ No
Psychiatric/Psychological	☐ Yes	☐ No

Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No

Women:

Pregnant? ☐ Yes ☐ No How many months? ________
Nursing? ☐ Yes ☐ No
Taking birth control pills? ☐ Yes ☐ No

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Dental Health Questionnaire

What is the reason for your visit today? ______________________________

Date of Last Dental Visit ____________ Reason for last Dental Visit ______________________

Date of Last Cleaning ____________

Are you having any dental problems now? ☐ Yes ☐ No

If yes, please describe: ____

Are any of your teeth sensitive to:

- Hot or Cold? ☐ Yes ☐ No
- Sweets? ☐ Yes ☐ No
- Biting or Chewing? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Any gum disease in family member? ☐ Yes ☐ No

Have you noticed any loose teeth? ☐ Yes ☐ No

Have you noticed a change in bite? ☐ Yes ☐ No

Does food get caught in your teeth? ☐ Yes ☐ No

Do you:

- Clench or grind your teeth? ☐ Yes ☐ No
- Bite your lips or cheeks regularly? ☐ Yes ☐ No
- Hold foreign objects with your teeth? ☐ Yes ☐ No
  (i.e. pencils, pipe, pins, nails, fingernails)
- Have tired jaws, especially in the morning? ☐ Yes ☐ No

Have you noticed or experienced:

- Clicking or popping of the jaw? ☐ Yes ☐ No
- Pain? (joint, ear, side of face) ☐ Yes ☐ No
- Difficulty opening or closing mouth? ☐ Yes ☐ No
- Difficulty chewing on either side? ☐ Yes ☐ No
- Headaches or shoulder aches? ☐ Yes ☐ No
- Sore jaw muscles? ☐ Yes ☐ No

Satisfied with your teeth's appearance? ☐ Yes ☐ No

Is keeping all of your teeth important? ☐ Yes ☐ No

Do you feel nervous about treatment? ☐ Yes ☐ No

if so, what is your biggest concern? ____________

Have you ever had an upsetting dental experience? ☐ Yes ☐ No

If yes, describe:________________________

If you could change anything about your teeth, shape, color, or bite, what would you change? ____________

____

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, describe:____

____

Would you like to have nitrous gas(laughing gas) for treatment? ☐ Yes ☐No

Would you like to be sedated for dental treatment? ☐ Yes ☐No

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I understand the information I provided on Patient registration, Medical history, and Dental history forms is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provided or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

I hereby authorize doctor or designated staff to take radiographs, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2 % late charge (18% APR) may be added to my account. If required, I also understand that a check of my credit may be made.

I give consent to the doctor’s or designated staff’s use and disclosure of any oral, written or electronic health records that are individually identifiable as my dependants or mine for the purposes of carrying out my treatment, payment and health care operation. You may revoke this consent at anytime be giving us a written notice of your revocation by certified mail.

I authorize Wylie Village Dentistry PA to submit claims for payment for services to my dental or medical insurance company, on my behalf and in my name, and assign such provider the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for any balances not satisfied by my insurance benefits, regardless of the basis for nonpayment by my insurance carrier.

Patient/Guardian Signature ____________________________ Date_________