Windham Dental Center Welcomes You

Donna I. Kalil, DMD Kenneth J. Kalil, DMD

Patient Information

Name____**DOB**_________________**SS#**____________________

Address____

City____ **State**____________________ Zip______________

Home Phone_________________________**Work #**________________________**Cell#**________________________

Email Address:____

Circle Appropriate: Single Married Divorced Widowed Child Full-time Student? Y or N

If F-T Student: Name of College, Including City and State: ____

Patient/Guardian Employer_________________________________**Address**__________________________________

Occupation _____________________**How Did You Hear About Our Office?**________________________________

Emergency Contact____**Phone**__________________________________

Dental History

Previous Dentist_____________________**Address**_____________________**Date of Last Visit**_________________

Date of Last X-Rays: *Full Mouth*: ___________________________ *Bitewings*: __________________________

NOTE: If possible, please obtain a copy of the most recent x-rays and bring them with you to your first visit, or have the dentist send them directly to Windham Dental Center. Thank you.

Dental Insurance Information

(We will need to make a copy of your insurance ID Card)

Name of Policy Holder______________________________________ Relationship to Patient__________________

DOB________________ **SS#**________________________ Date Employed________________________

Policy Holder Employer____ Work #_________________________

Employer Address______________________________________ City____________________State_________

Insurance Company____Group#____________________

Ins.Address______________________City_______________State_____Zip________Phone___________________

Over Please

Patient Medical History

Physician______________________________Office Phone__________________Date of Last Exam_____________

1. Are you Under Medical Treatment now? Y or N
2. Have you ever been hospitalized for any operation/surgery in the last 5 years? Y or N

If yes, please explain:____

3. Are you taking any medication(s) including over the counter? Y or N

If yes, what medications? ______________________ ______________________

______________________ ______________________ ______________________

4. Do you use Tobacco? Y or N
5. Do you use controlled substances? Y or N
6. Do you have or have you had any of the following?

Aids/HIV	Y or N	Glaucoma	Y or N	Liver Disease	Y or N
Anemia	Y or N	Hay Fever	Y or N	Low Blood Pressure	Y or N
Angina	Y or N	Heart Attack	Y or N	Mitral Valve Prolapse**	Y or N
Arthritis	Y or N	Heart Disease	Y or N	Pacemaker	Y or N
Asthma	Y or N	Heart Murmur**	Y or N	Radiation TX	Y or N
Cancer	Y or N	Heart Trouble	Y or N	Rheumatic Fever	Y or N
Chest Pains	Y or N	Hepatitis	Y or N	Stroke	Y or N
Diabetes	Y or N	High Blood Pressure	Y or N	Thyroid Problems	Y or N
Emphysema	Y or N	Joint Replacement**	Y or N	Tuberculosis	Y or N
Epilepsy/Convulsions	Y or N	Kidney Disease	Y or N	Weight Loss (Recent)	Y or N
Fainting/Seizures	Y or N	Leukemia	Y or N		

** If you answered yes to any of these conditions, do you need to pre-medicate prior to dental visits Y or N

If yes, name of medication: ___________________________________

7. Are you allergic to or have you had any reaction to the following?

Aspirin	Y or N
Barbiturates	Y or N
Iodine	Y or N
Latex	Y or N
Local Anesthetics (e.g. Novocain)	Y or N
Metals (e.g. nickel, mercury, etc.)	Y or N
Penicillin or any other Antibiotic	Y or N
Sedatives	Y or N
Sulfa Drugs	Y or N

Other: ____

8. WOMEN ONLY:

Are you pregnant or think you may be pregnant? Y or N

Are you nursing? Y or N

Are you taking oral contraceptives? Y or N

DENTAL HISTORY:

1. Do your gums bleed easily? Y or N
2. Are your teeth sensitive to hot, cold or sweets? Y or N
3. Do you have any pain in your teeth? Y or N
4. Have you ever had prolonged bleeding after an extraction? Y or N
5. Have you ever experienced any of the following problems?

   Jaw Clicking Y or N Jaw Pain Y or N Difficulty Opening Y or N
6. Do you have frequent headaches? Y or N
7. Do you clench or grind your teeth? Y or N
8. Have you had orthodontics? Y or N
9. Do you wear a denture/partial Y or N
10. Have you received oral hygiene instructions regarding your gums? Y or N
11. Do you like your smile? Y or N

X____ Date____________________________

Patient Signature/Legal Guardian