

# Kalil Dental Associates, Inc

Kenneth J Kalil, DMD

Thank you for choosing our office

## Patient Information

Name: \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

May we call you at work regarding appointments? Y\_ N\_\_

Marital status: Married \_\_\_ Widow(er) \_\_\_ Divorce \_\_\_ Separated \_\_\_

Full time college student? Y\_ N\_\_ If so, name and address of College: \_\_\_\_\_

Patient/Guardian's Employer: \_\_\_\_\_ Address \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

In case of emergency please call: \_\_\_\_\_

## Dental Information

Previous Dentist Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of last cleaning and exam \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

**\*\*\*\*Note :** IF POSSIBLE, PRIOR TO YOUR VISIT WITH US, PLEASE HAVE YOUR RECORDS/x-RAYS sent to OUR OFFICE:  
KALIL DENTAL ASSOCIATES, INC 91 JACKSON STREET MEXICAN, MA 01844

## Dental Insurance

(Please present insurance card for insurance verification)

Name of policy holder \_\_\_\_\_ Relationship to policy holder : SELF: \_\_\_ Spouse \_\_\_ Child \_\_\_

DOB \_\_\_\_\_ SS# or Insurance ID # of policy holder \_\_\_\_\_ Group # \_\_\_\_\_

Employer: \_\_\_\_\_ Address \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_

Insurance Company Name and Address: \_\_\_\_\_

Physician \_\_\_\_\_ Telephone# \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1) Are you under medical treatment now? Y\_\_ N\_\_

If yes, for what? \_\_\_\_\_

2) Have you ever been hospitalized for any operation in the last 5 years Y\_\_ N\_\_

If yes, please explain \_\_\_\_\_

3) Are you taking any medication(s) including over the counter meds Y\_\_ N\_\_

4) List Medications: \_\_\_\_\_  
\_\_\_\_\_

5) Do you use controlled substances? Y\_\_ N\_\_

6) Do you have or have you had any of the following?

|                      |         |                              |              |                    |         |
|----------------------|---------|------------------------------|--------------|--------------------|---------|
| AIDS/HIV             | Y__ N__ | Glaucoma                     | Y__ N__      | Kidney Disease     | Y__ N__ |
| Anemia               | Y__ N__ | Hay fever                    | Y__ N__      | Leukemia           | Y__ N__ |
| Angina               | Y__ N__ | Heart Attack                 | Y__ N__      | Liver Disease      | Y__ N__ |
| Asthma               | Y__ N__ | Heart Murmur /MVP            | Y__ N__      | Pacemaker          | Y__ N__ |
| Cancer               | Y__ N__ | Hepatitis                    | Y__ N__      | Radiation          | Y__ N__ |
| Chest Pains          | Y__ N__ | High/Low blood               | Y__ N__      | Rheumatic fever    | Y__ N__ |
| Diabetes             | Y__ N__ | Pressure                     | High__ Low__ | Stroke             | Y__ N__ |
| Epilepsy/convulsions | Y__ N__ | ** Joint replacement         | Y__ N__      | Thyroid            | Y__ N__ |
| Fainting/seizures    | Y__ N__ | if yes, when was the surgery | _____        | TB                 | Y__ N__ |
| Prolonged bleeding   | Y__ N__ | what type of replacement     | _____        | Recent weight loss | Y__ N__ |

\*\* Heart Valve replacement Y\_\_ N\_\_

**\*\*Indicates patient who had joint replacement and or heart valve replacement will need to Pre-Medicare With any Antibiotic prior to all dental procedures.**

7) Are you allergic to or had a reaction to any of the following:

|                                       |         |                               |         |
|---------------------------------------|---------|-------------------------------|---------|
| Penicillin                            | Y__ N__ | Aspirins                      | Y__ N__ |
| Amoxicillin                           | Y__ N__ | Barbiturates                  | Y__ N__ |
| Sulfa Drugs                           | Y__ N__ | Iodine                        | Y__ N__ |
| Latex                                 | Y__ N__ | or any other drugs no listed: | _____   |
| Local anesthesia                      | Y__ N__ | _____                         | _____   |
| Metals (e.g. Nickel, mercury, etc...) | Y__ N__ | _____                         | _____   |

8) **Women only:**

|  |         |                          |       |
|--|---------|--------------------------|-------|
| Are you Pregnant or think you may be pregnant? | Y__ N__ | if yes, when are you do? | _____ |
| Are you nursing                                | Y__ N__ |                          |       |
| Taking birth control pills                     | Y__ N__ |                          |       |

### **Dental history:**

Do your gums bleed easily? Y\_\_ N\_\_

Are your teeth sensitive to hot/cold or sweets Y\_\_ N\_\_ if yes, which \_\_\_\_\_

Do you have any pain in your teeth Y\_\_ N\_\_

Have you ever experienced any of the following problems?

Jaw pain\_\_ Jaw clicks or pops when opening /closing\_\_ frequent headaches Y\_\_ N\_\_

Do you clench or grind your teeth? Y\_\_ N\_\_

Do you smoke and or chew tobacco? Y\_\_ N\_\_

\*\*\*\*IN ADDITION TO PERFORMING A ROUTINE ORAL CANCER EVALUATION, WE NOW RECOMMEND VIZILITE WHICH IS AN ADVANCED ORAL CANCER SCREENING. WOULD YOU LIKE TO HEAR MORE INFORMATION ABOUT THIS PROCEDURE? Y\_\_ N\_\_

Are you happy with your smile? Y\_\_ N\_\_ Do you feel they could be whiter or straighter? Y\_\_ N\_\_

We now offer Invisalign would you be interested? Y\_\_ N\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Signature of patient