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At Drs. Kirkpatrick and Lai, we treat people, not just teeth. We care about total health and appreciate your time in completing this health history.

PATIENT HISTORY				
Patient's Name	Goes By			Date
Address	City	State	Zip	Home Phone
Sex	Age	Birthdate		Work Phone
School/Employer		Grade/Position		Cell Phone
Father/Husband				Marital Status
Address	City	State	Zip	Home Phone
Employer		Position		Work Phone
				Cell Phone
Mother/Wife				Marital Status
Address	City	State	Zip	Home Phone
Employer		Position		Work Phone
				Cell Phone
Siblings	Name/Age	Name/Age	Name/Age	
How did you hear about our office?				
Patient Email		Parent Email		

BILLING INFORMATION				
Billing Name				Relation to Patient
Address	City	State	Zip	Home Phone
Social Security No.		Employer		Work Phone

INSURANCE INFORMATION		
Insured's Name		Insured's Employer
Insurance Company (if you have Dual Coverage List Both)		
Insured's Social Security No.	Group No.	Insured Date of Birth
Insured's Social Security No.	Group No.	Insured Date of Birth

Responsible Party Signature _____

DENTAL HISTORY	
Dentist	Date of Last Visit
Address	Phone
What concerns you most about your teeth?	
<i>Please circle Yes or No (if Yes, please fill in details)</i>	
YES / NO	Do you have an appointment with your dentist for dental work?
YES / NO	Have you ever had trauma to your mouth or teeth?
YES / NO	Is any part of your mouth sensitive to temperature or pressure?
YES / NO	Do your gums bleed when you brush?
YES / NO	Do you have any type of thumb sucking or tongue thrusting habit?
YES / NO	Have you ever been examined by an orthodontist?
YES / NO	Has anyone in the family received orthodontic treatment? How did they feel about the result?
YES / NO	Do you have any pain or soreness around your face or neck?
YES / NO	Are your teeth or jaws ever uncomfortable when you awaken in the morning?
YES / NO	Are you aware of your jaw clicking or popping?
YES / NO	Are you aware of grinding your teeth during the day or night?
YES / NO	Do you have "tension" headaches?

MEDICAL HISTORY	
Physician	Date of Last Visit
Address	City State Zip Phone
	Are you taking any medication?
	Are you allergic to any medication?
	Have you had any major operations?
	Have you ever been involved in a serious accident?
<i>(Circle any of the medical conditions below that you have had or currently have)</i>	
HIV	Asthma or Hayfever
Anemia	Diabetes
Arthritis	Dizziness
Eating Disorders	Heart Problems
Hepatitis	
Herpes	High Blood Pressure
Pregnancy	
Tuberculosis	Tumor or Cancer
	Venereal Disease
Are there any medical conditions we have not discussed that you feel we should be made aware of?	