



Thomas B. Kirkpatrick, D.D.S., M.S.
 Douglas A. Kirkpatrick, D.D.S., M.S.
 Joseph Lai, D.D.S., M.S.

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		Nickname		Date
Address	City	State	Zip	Home Phone
Sex	Age	Birthdate		Work Phone
School/Employer				Grade/Position
Father/Husband				Marital Status
Address	City	State	Zip	Home Phone
Employer	Position			Work Phone
Mother/Wife				Marital Status
Address	City	State	Zip	Home Phone
Employer	Position			Work Phone
Siblings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name/Age	Name/Age	Name/Age
How did you hear about our office?		Parent Email	Patient Email	

BILLING INFORMATION			
Billing Name			Relation to Patient
Address	City	State	Zip
Home Phone		Work Phone	
Social Security No.	Employer		Work Phone
For those patients that will not be paying for treatment in full and will be setting up a payment plan, we will require the billing portion of our patient information sheet be completed in its entirety. These patients will be subject to credit evaluation.			

INSURANCE INFORMATION		
Insured's Name		Insured's Employer
Insurance Company (If you have Dual Coverage List Both)		
Insured's Soc. Sec. No.	Group No.	Local No.
Insured's Soc. Sec. No.	Group No.	Local No.

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	Have you ever experienced any unfavorable reaction to dentistry?
YES / NO	Have you ever lost or chipped any 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 or tongue 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, neck or back?
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?
YES / NO	Have you ever been told that you grind your teeth?
YES / NO	Do you have "tension" headaches?
YES / NO	Have you ever experienced ringing in your ears?

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>				
AIDS	Asthma or Hayfever	Eating Disorders	Herpes	Tuberculosis
Anemia	Diabetes	Heart Problems	High Blood Pressure	Tumor or Cancer
Arthritis	Dizziness	Hepatitis	Pregnancy	Venereal Disease
Are there any medical conditions we have not discussed that you feel we should be made aware of?				