Welcome to the office of Kevin Barrett, D.D.S.

We are pleased that you have selected us as your dental care provider.
To help us serve you better, please complete both sides of this patient information form.

Today's Date: _____

PATIENT INFORMATION

Last Name _____ First Name _____
Address_____
City, State _____Zip _____
Home Phone _____Work Phone _____Mobile _____
Birth date _____ Sex M __F __ Social Security Number _____
Employer_____
Student: Yes ____No ____Name of School _____
Name of Emergency Contact _____Phone Number _____

INSURANCE INFORMATION

Last Name of Employee _____First Name _____
Address _____
City, State _____Zip _____
Home Phone _____Work Phone _____Mobile _____
Employer _____Relationship to Patient ___Self __Spouse ___Child ___
Birth date _____ Sex M __F __ Social Security Number _____
Name of Insurance Co. _____Phone Number _____
I.D. Number _____Group Number _____

SECONDARY INSURANCE INFORMATION

Last Name of Employee _____First Name _____
Address _____
City, State _____Zip _____
Home Phone _____Work Phone _____Ext. _____
Employer _____Relationship to Patient ___Self __Spouse ___Child ___
Birth date _____ Sex M __F __ Social Security Number _____
Name of Insurance Co. _____Phone Number _____
I.D. Number _____Group Number _____

AUTHORIZATION

I certify that I have read the above information. The above questions have been answered accurately to the best of my knowledge. I authorize Dr. Kevin Barrett to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and or health practitioners. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for my payment in full.

Signature of Patient: _____
(or parent if minor)

Date: _____

DENTAL HISTORY

To help us provide you with the best possible care, please answer all questions on this dental/medical history form. All information is completely confidential.

Reason for today's visit _____

Date of last dental visit _____Date of last cleaning _____

Former dentist _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Occupation: _____

Please answer the following questions.

Y N Do your gums bleed or hurt?

Y N Have you noticed any loose teeth or change in your bite?

Y N Does food tend to become caught between your teeth?

Y N Do you clench or grind your teeth?

Y N Do you have tired jaws or jaw pain?

Y N Do you smoke or chew tobacco?

Y N Do you have tooth pain?

Y N Have you ever had periodontal treatment?

Y N Have you experienced dry mouth?

Y N Have you experienced sores/growths in mouth?

Y N Have you experienced swollen or tender gums?

Y N Are you satisfied with the appearance of your teeth?

HEALTH HISTORY

Physician's Name _____Date of last visit: _____

Please indicate if you have now or have had in the past:

Y N AIDS
Y N Anemia
Y N Arthritis, rheumatism
Y N Artificial heart valves
Y N Artificial joints
Y N Asthma
Y N Hepatitis Type _____
Y N Bypass surgery
Y N Abnormal bleeding w/extractions, surgery
Y N Blood disease
Y N Cancer
Y N Liver disease
Y N Chemotherapy
Y N Congenital heart lesions
Y N Venereal disease
Y N Cough, persistent or bloody
Y N Diabetes
Y N Emphysema
Y N Scarlet fever
Y N Sinus trouble
Y N Stroke
Y N Swollen neck glands
Y N Epilepsy
Y N Fainting or dizziness
Y N Heart murmur
Y N Heart problems
Y N Tonsillitis
Y N Herpes
Y N High blood pressure
Y N HIV positive
Y N Kidney disease
Y N Tuberculosis
Y N Thyroid problems
Y N Low blood pressure
Y N Mitral valve prolapse
Y N Nervous problems
Y N Pacemaker
Y N Are you pregnant
Y N Are you nursing
Y N Psychiatric care
Y N Radiation Treatment
Y N Respiratory disease
Y N Rheumatic fever
Y N Shortness of breath
Y N Ulcer
Y N Stints/shunts

Please list any medical condition(s) that you have ever had:

_____

_____

Please list all medications you are currently taking:

_____

_____

Are you allergic to any of the following:

Y N Aspirin
Y N Erythromycin
Y N Codeine
Y N Iodine
Y N Latex
Y N Local anesthetics
Y N Penicillin
Y N Sulfa
Y N Tetracycline

Other allergies: _____