KITS ENDO

PERSONAL INFORMATION

Name:_____ Preferred Name:_____

Address:_____ Date of Birth: M_____D _____Y_____

_____ Postal Code_____Sex: M ____F____U____

Email Address_____

I authorize contact from Kits Endo via email/text message YES NO

(Including Appointment Reminders, Product Information and Promotions)

Phone: Cell_____ Alternate _____

Preferred Method of Contact: (Please circle) Phone Email Text/SMS All Methods

Whom may we thank for referring you? _____

INSURANCE

Name_____	Name_____
Birthdate M___D____Y____	Birthdate M___D____Y____
Insurance Carrier_____	Insurance Carrier_____
Employer_____	Employer_____
Policy/Group #_____	Policy/Group #_____
Insured ID/Certificate #_____	Insured ID/Certificate #_____

I authorize Kits Endo to submit claims electronically on my behalf. NO YES

DENTAL HISTORY

1. Name of General Dentist _____
2. When was your last dental visit? _____
3. When did you last have dental x-rays? _____
4. How often do you brush your teeth? 1x day 2x day 3xday Other _____
5. Do you use manual toothbrush or electric toothbrush? Manual_____ Electric_____
6. How often you floss you teeth? _____
7. List any other oral hygiene measures you use: (e.g. rinses, waterpik, mouthwash)
   _____
8. Do your gums bleed? No Yes If so where? _____
9. Do you have any pain anywhere in your face or jaw? No Yes If so where? _____
10. Do you feel you have bad breath? No Yes
11. Have you ever had an injury to your jaw or face? No Yes If so where? _____
12. Have you ever had dental implant surgery? No Yes If so where? _____
13. Have you ever had orthodontic (braces) treatment? No Yes
14. Do you have sore or sensitive teeth? No Yes If so where? _____
15. Do you Clench or Grind your teeth? No Yes
16. How often do you go for regular hygiene visits? _____
17. Have you ever had gum surgery before?_____
18. Please list any concerns you may have _____
    _____

KITS ENDO

MEDICAL HISTORY

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private. We will review the questions and explain any you do not understand. Please fill in the entire form.

1. Name of Physician_____#_____
2. Emergency Contact: Name_____ #_____
   Relationship _____
3. Drug / Food Allergies_____
4. Are you taking any medications, non-prescriptive drugs or herbal supplements of any kind? Please list
   _____
5. Have you ever been advised to take antibiotics prior to dental work for a **heart murmur**, **mitral valve prolapse**, **rheumatic fever** or for **an artificial joint**? No Yes
   If so, please specify_____
6. Are you taking any Bisphosphonate drugs? (Fosamax, Actonel, Boniva, Didronel) No Yes
   If so, please specify _____
7. List any medical conditions you are being treated for or have been treated for
   _____
8. Do you have or have you ever had any of the following?

	No	Yes		No	Yes
1. Hepatitis, jaundice, liver disease……..	__	__	18. Medical Radiation Treatments…….	__	__
2. Rheumatic Fever …….....	__	__	19. Abnormal Bleeding Problems…….	__	__
3. Heart Murmur …….....	__	__	a. Take Aspirin Daily……...	__	__
4. Heart Trouble or Stroke…….....	__	__	b. Clotting problems…….……	__	__
5. High or Low Blood Pressure …….....	__	__	c. Other Blood Problems…….....	__	__
6. Chest Pain, swollen ankles or breath shortness	__	__	20. Are you a nervous person? ……..	__	__
7. Drug reactions? …….	__	__	Do you take medications for this condition?.	__	__
If yes, What? _____			21. Have you had a serious illness or conditions		
8. Asthma, hay fever, sinus problems or allergies?	__	__	that we should know about.? …….	__	__
9. Epilepsy or seizures …….....	__	__	If yes, what _____		
10. Diabetes…….....__	__		22. Do you smoke? No Yes If yes how much _____		
11. Arthritis or Rheumatism……_	__		WOMEN		
12. Stomach or duodenal ulcers……...	__	__	23. Are you pregnant? ……...	__	__
13. Kidney Disease …….	__	__	24. Do you take birth control pills?……	__	__
14. Venereal Disease. HIV. Aids……__	__		25. Are you post menopause?……..	__	__
15. Glaucoma …….....	__	__	26. Do you have any problems with your		
16. Cancer ……_	__		menstrual cycle? ……	__	__

CONSENT TO TREATMENT AND OFFICE POLICY

1. I authorize the doctor upon consultation and direct consent from the patient/parent/guardian to perform diagnostic procedures, treatment, x-rays and medication in the connection with the patient's dental needs.
2. I understand that the responsibility for payment of dental services, including insurance or otherwise, is due and payable at the time of services rendered and despite any dental insurance I am ultimately responsible for any fees withheld by the insurance company.
3. I understand that I must provide 48 business hours to cancel or reschedule my appointments to avoid any fees.

To the best of my knowledge all of the preceding answers are true and correct. If there are any changes I will without fail inform the Kits Endo at my next appointment.

_____ _____

Signature (Patient/Parent/Guardian) Date