JINA L. KAISER, D.D.S.

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name ______________________________ Preferred name ____________

Please Circle: Single Married Divorced Widowed Gender: M F

Birth date __________ Social Security number: ______________

Mailing address ______________________________ City __________ State ______ Zip ________

Home phone __________ Cell phone ______________ Email __________________________

If child, parents name ______________________________

Employer ______________________ Business phone __________________________

Spouse's name ______________________ Spouse's employer ________________________

Whom may we thank for referring you to our office? ______________________________

Person to contact in the event of an emergency? ______________________________

MEDICAL HEALTH HISTORY

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

- ❑ Cancer ___ Radiation Therapy ___ Chemotherapy
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease Type:______
- ❑ Alcoholism, drug addiction
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emphysema
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Glaucoma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to or reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:______________ ______________

Have you had COVID-19? _____ Date:______________

Have you had the COVID-19 vaccine? ___ Date: __________

Please list all medications you are currently taking:

____

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Women:

- ❑ May be pregnant
  Expected delivery date: __________
- ❑ Taking hormones or contraceptives

Name of your physician: ______________________________

Do you have any disease, condition, or problem not listed above? ______________________________

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Please add anything else you would like us to know about: ______________________________

____

Signature of patient (or parent) ______________________________ Date ______________