



# Gardner Dental Care

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971 East Lincoln • Gardner, KS 66030 • (913) 856-7123

Date \_\_\_\_\_

1. **Patient's Name** \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Last First Middle

2. Address \_\_\_\_\_  
Street City State Zip

3. Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

4. Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_

5. **Person Responsible for Payment** \_\_\_\_\_  
Last First Middle

6. Address \_\_\_\_\_  
Street City State Zip

7. Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

8. Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

9. Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

10. **Spouse Information** \_\_\_\_\_  
Last First Middle

11. Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

12. Work Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

### DENTAL INSURANCE INFORMATION (we need a copy of your card)

13. Insured's Name (employee) \_\_\_\_\_  
Last First Middle

14. Insured's Birthdate \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

15. Insured's Address (if different from above) \_\_\_\_\_

16. Insured's Employer \_\_\_\_\_

17. Insurance Co. Name & Address \_\_\_\_\_

### EMERGENCY INFORMATION

18. Local Friend or Relative not living with you \_\_\_\_\_

19. Complete Address \_\_\_\_\_

20. Phone No. \_\_\_\_\_

### GETTING TO KNOW YOU

21. Why did you select our office? \_\_\_\_\_

22. Whom may we thank for referring you \_\_\_\_\_

23. Is another member of your family or relative a patient in our practice \_\_\_\_\_

24. When was your last dental visit? \_\_\_\_\_

25. When was the last time you had complete dental X-rays taken? \_\_\_\_\_ Dentist: \_\_\_\_\_

26. Have you ever had any teeth removed? \_\_\_\_\_

How long have these teeth been missing? \_\_\_\_\_

Have these teeth been replaced? \_\_\_\_\_

How?  Bridge  Partial  Denture  Implants

### PAYMENT ALTERNATIVES

Please check appropriate box:

- 1. Mastercard, Visa, Discover and American Express.
- 2. For long term or extended payments, we offer a healthcare financing program, which when you are accepted, will allow 90 days no interest and extended small monthly payments for treatment received.

### FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistant as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP

DATE

# MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?.....  YES  NO  
If yes, for what reason? \_\_\_\_\_
2. Please provide the name, address, and telephone number of your physician.  
\_\_\_\_\_
3. Are you having dental problems at this time?.....  YES  NO
4. Do your gums bleed at any time?.....  YES  NO
5. Do you feel very nervous about having dental treatment? .....  YES  NO
6. Have you ever had a bad experience in the dental office? .....  YES  NO
7. Have you been a patient in the hospital during the past two years? .....  YES  NO  
If yes, please list. \_\_\_\_\_
8. Have you taken any medicine or drugs during the past two years? .....  YES  NO
9. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? .....  YES  NO  
If yes, please list. \_\_\_\_\_
10. Have you ever had excessive bleeding requiring special treatment? .....  YES  NO
11. Check any of the following which you have had or have at present:
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heart Failure                | <input type="checkbox"/> Shortness of Breath             | <input type="checkbox"/> HIV Positive (AIDS)                    |
| <input type="checkbox"/> Heart Disease or Attack      | <input type="checkbox"/> Emphysema                       | <input type="checkbox"/> Hepatitis A (Infectious)               |
| <input type="checkbox"/> Angina Pectoris (chest pain) | <input type="checkbox"/> Hepatitis B (Serum)             | <input type="checkbox"/> High Blood Pressure                    |
| <input type="checkbox"/> Tuberculosis (TB)            | <input type="checkbox"/> Liver Disease                   | <input type="checkbox"/> Heart Murmur/Mitral Valve              |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Yellow Jaundice                 | <input type="checkbox"/> Bruise Easily                          |
| <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> Hay Fever                       | <input type="checkbox"/> Blood Transfusion                      |
| <input type="checkbox"/> Congenital Heart Lesions     | <input type="checkbox"/> Allergies or Hives              | <input type="checkbox"/> Drug Addiction                         |
| <input type="checkbox"/> Scarlet Fever                | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Hemophilia                             |
| <input type="checkbox"/> Artificial Heart Valve       | <input type="checkbox"/> Thyroid Disease                 | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) |
| <input type="checkbox"/> Heart Pacemaker              | <input type="checkbox"/> X-Ray or Cobalt Treatment       | <input type="checkbox"/> Cold Sores or Fever Blisters           |
| <input type="checkbox"/> Heart Surgery                | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> Genital Herpes                         |
| <input type="checkbox"/> Artificial Joint             | <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Epilepsy or Seizures                   |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Rheumatism                      | <input type="checkbox"/> Fainting or Dizzy Spells               |
| <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Cortisone Medication            | <input type="checkbox"/> Nervousness                            |
| <input type="checkbox"/> Kidney Trouble               | <input type="checkbox"/> Glaucoma                        | <input type="checkbox"/> Psychiatric Treatment                  |
| <input type="checkbox"/> Ulcers                       | <input type="checkbox"/> Pain in Jaw Joints              | <input type="checkbox"/> Sickle Cell Disease                    |
12. List all medications you are taking at this time. \_\_\_\_\_
13. Are you a smoker?.....  YES  NO
14. Do you use or have you ever used recreational drugs? .....  YES  NO
15. When you walk up stairs or take a walk, do you have to stop because of pain in your chest. or shortness of breath or because you are very tired? .....  YES  NO
16. Do your ankles swell during the day?.....  YES  NO
17. Have you lost or gained more than 10 pounds in the last year?.....  YES  NO
18. Do you use more than 2 pillows to sleep?.....  YES  NO
19. Do you ever wake up from sleep short of breath? .....  YES  NO
20. Are you on a special diet? .....  YES  NO
21. Has your medical doctor ever said you have cancer or a tumor?.....  YES  NO
22. Women: Are you pregnant?  YES  NO If yes, what month are you due? \_\_\_\_\_  
Are you taking birth control pills? .....  YES  NO
- Do you have any disease, condition or problem not listed? .....  YES  NO  
If yes, please list. \_\_\_\_\_
  - How do you feel about getting and maintaining a healthy mouth? \_\_\_\_\_
  - How do you feel about the appearance of your teeth? \_\_\_\_\_
  - If you could change anything about your smile, what would you change? \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_