® WELCOME ®

KEVIN J. REECE, D.D.S.
Family Dentistry

97 South Professional Way
Payson, Utah 84651
(801)465-4474

ABOUT YOU

Today's Date_____

Name:_____

I prefer to be called:_____ □ Male □ Female

Birthdate:_____/_____/_____Age:_____

Home Address:_____
Apt/Condo #

City State zip code

□ Single □ Married □ Divorced □ Widowed □ Separated

Home #:_____Cell/Other#:_____

Work #:_____Ext._____E-mail_____

Employer:_____

Employer's Address:_____

How long there?_____Occupation:_____

Where & When are the best times to reach you?_____

Whom may we Thank for referring you?_____

Other family members seen by us:_____

Previous/Present Dentist:_____

Last Visit Date:_____

SPOUSE INFORMATION

His/Her Name:_____

Employer:_____

Work #:_____Ext:_____DL#:_____

Birthday:___/___/___ Age:_____

Person Responsible for Account:_____

Work #_____Ext:____

Billing Address:_____

Relationship:_____

Employer:_____

DENTAL INSURANCE

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #:_____

Group #_____ID#_____

Insured's Name:_____Relation_____

Insured's Birthday____/____/____

Insured's Employer:_____

SECONDARY DENTAL INSURANCE

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #:_____

Group #_____

Insured's Name:_____Relation_____

Insured's Birthday____/____/____

Insured's Employer:_____

In the event of an emergency, is there someone
Who lives near you that we should contact?
Name:_____Phone:_____

Relation:

MEDICAL HISTORY

Do you have a personal physician? □ No □ Yes

Physician's Name:_____

Phone #:_____Date of last visit_____

CONTINUED ON BACK OF FORM

MEDICAL HISTORY

Your current physical health is ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician ☐ Yes ☐ No
If so please explain_____
Are you taking any prescription/over-the-counter drugs ☐ Yes ☐ No
Please list each one_____
_____

For Women Are you taking birth control pills?☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week #_____
Are you nursing? ☐ Yes ☐ No

DENTAL HISTORY

Why have you come to the dentist today?_____
_____
Are you currently in pain? ☐ Yes ☐ No
Have you ever had a serious/difficult problem associated with
Any previous dental work? ☐ Yes ☐ No
Do you now or have you ever experienced pain/discomfort in
Your jaw joint (TMJ/TMD)? ☐ Yes ☐ No
Your current physical health is ☐ Good ☐ Fair ☐ Poor
Do you like your smile? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No
How many times a day do you floss? __a day – brush a day__
Type of bristles? ☐ Hard ☐ Medium ☐ Soft

Have you ever had any of the following Diseases or Medical problems

Y N Severe/Frequent Headaches
Y N Heart Attack/Stroke
Y N Cancer/Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV+/AIDS
Y N Heart Surgery/Pacemaker
Y N Shingles
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Sinus Problems
Y N High/Low Blood Pressure
Y N Hepatitis
Y N Emphysema/Glaucoma
Y N Anemia/Radiation treatment
Y N Psychiatric Problems
Y N Epilepsy/Seizures/Fainting Spells
Y N Diabetes/Tuberculosis (TB)
Y N Drug/Alcohol Abuse
Y N Venereal Disease
Y N Hemophilia/Abnormal Bleeding
Y N Ulcers/Colitis
Y N Congenital Heart Defect
Y N Asthma/Arthritis
Y N Difficult Breathing
Y N Hospitalized for any reason
Y N Blood Transfusion

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

Are you allergic to any of the following drugs?
Y N Penicillin Y N Tetracycline Y N Latex Y N Aspirin
Y N Dental Anesthetics Y N Erythromycin Y N Codeine Y N Other

Please list any other drugs that you are allergic to:_____
_____

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT AND CONSENT TO PRODEED

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Kevin J. Reece, DDS and/or such associates or assistants as she/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature_____Date___/___/___Witness_____Date___/___/___
(Patient, Legal Guardian or authorized agent of Patient)

OFFICE USE ONLY **OFFICE USE**

I verbally reviewed the medical/dental information above with the patient named herein:
Initials Date

Doctor's
Comments:_____

MEDICAL HISTORY UPDATE

1.
Date_____Comments_____Signature_____
2.
Date Comments Signature