Jeff Kindseth, DDS
Cosmetic & General Dentistry

We are complimented that you have selected us to provide dental care for you and your family.

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

Patient Information

Date__________ Patient's Name ____
Last First Middle

Address ____
Street City State Zip

Cell Ph. # (____)__________________ Home Ph. # (____)__________________ Work Ph. # (____)__________________

Birthdate ___/___/___ Sex M F If patient is a minor, give parent's/guardian's name ______________________

Email ______________________________ Contact Preferences ❑Cell ❑Home ❑Work ❑Email

Soc. Sec. #_______-_______-_______ Drivers Lic. #______________________

Emergency Contact ______________________________Ph. # (____)__________________

Responsible Party Information

Name ____
Last First Middle Martial Status

Soc. Sec. #_____-_____-_____ Birthdate ______/______/______ Relationship to Patient______________________

Residence ____
Street City State Zip

Mailing Address ____
Street City State Zip

Cell Ph.# (____)__________________ Home Ph.# (____)__________________ Work Ph.# (____)__________________

Previous Address (if less than 3 years) ______________________________________

Employer__________________ Occupation __________________ No. Years Employed__________

Employer Address ____

Spouse's Name ______________________________ Relationship to Patient ______________

Soc. Sec. #_____-_____-_____ Birthdate ______/______/______ Work Ph.# (____) __________________

Employer__________________ Occupation __________________ No. Years Employed__________

Employer Address ____

Dental Insurance Information

Insured's Name __________________ Insured's Birthdate __________________ Insured's Soc. Sec. # __________

Primary Insurance Company__________________ Subscriber ID: __________________ Group # __________

Insurance Co. Address ______________________________ Ph.#(____) __________________

Is policy connected with your union? ❑ Yes ❑ No Name of Union ______________________

Do you have dual coverage? ❑ Yes ❑ No If yes: Please complete the following secondary insurance information.

Insured's Name __________________ Insured's Birthdate __________________ Insured's Soc. Sec. # __________

Secondary Insurance Company__________________ Subscriber ID: __________________Group# __________

Insurance Co. Address ______________________________Ph.# (____) __________________

Insured's Employer ______________________________Ph.# (____) __________________

Dental Information

Do your gums bleed when you brush? ❑ Yes ❑ No

Are your teeth sensitive to heat or cold? ❑ Yes ❑ No Pressure ❑ Yes ❑ No Sweets ❑ Yes ❑ No

Do you grind or clench your teeth? ❑ Yes ❑ No

Do you have any fear of dental work? ❑ Yes ❑ No

Have you ever had a hard time getting numb? ❑ Yes ❑ No

Do you want to be sedated for dental work? (ie: Nitrous Oxide, sedatives, IV sedation) ❑ Yes ❑ No ❑ I'm not sure.

Date of last dental visit __________________What was done at the time?__________________

Former Dentist Name __________________City __________________

How would you describe your current dental problem?______________________________

How do you feel about the appearance of your teeth? ______________________________

Please complete back page

Medical Information

1. Are you having pain or discomfort at this time? .... YES NO
2. Have you been a patient in the hospital or had any surgeries in the last five years? .... YES NO
3. Are you taking any medications for osteoporosis? .... YES NO
   If yes, (Please list)________________
4. Are you taking any other medications or drugs during the last two years? .... YES NO
   If yes, (Please list)________________
5. Have you been under the care of a medical doctor during the last two years?
   Physician's Name________________ Ph. # (____) ________________
   Address ________________
6. Are you sensitive or allergic to any medication or anesthetics? .... YES NO
   If yes, (Please list)________________
7. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Heart Disease or Attack	YES	NO	Ulcers	YES	NO	A.I.D.S. / H.I.V. Positive	YES	NO
Angina Pectoris	YES	NO	Diabetes	YES	NO	Cold Sores/Fever Blisters	YES	NO
Congenital Heart Disorder	YES	NO	Thyroid Problems	YES	NO	Blood Transfusion	YES	NO
Heart Murmur	YES	NO	Glaucoma	YES	NO	Hemophilia	YES	NO
High Blood Pressure	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Arteriosclerosis	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Mitral Valve Prolapse	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Artificial Heart Valve	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Heart Pacemaker	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Heart Surgery	YES	NO	Allergies or Hives	YES	NO	Jaundice	YES	NO
Rheumatic Fever	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Arthritis	YES	NO	Cancer	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	YES	NO	Tumors	YES	NO	Nervousness	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Alzheimers Disease	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Dry Mouth	YES	NO
Stroke	YES	NO	Developmentally Disabled	YES	NO	Frequent Vomiting	YES	NO
Allergy to Latex	YES	NO	Allergy to Metal (jewelry, etc.)	YES	NO	Headaches	YES	NO
Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis A (infectious)	YES	NO	Osteoporosis	YES	NO
Kidney Trouble	YES	NO	Hepatitis B (or C)	YES	NO	Snoring/Sleep Apnea	YES	NO

11. Have you lost or gained more than ten pounds in the past year? .... YES NO
12. Do you ever wake up from sleep and feel short of breath? .... YES NO
13. Do you use tobacco? .... YES NO
14. Do you have or have you had any disease, condition, or problem not listed? .... YES NO
    If yes, (Please list)________________

FOR WOMEN ONLY:
• Are you pregnant? YES NO • What month? _____ • Are you nursing? YES NO • Are you taking birth control pills? YES NO

☐ **HIPAA CONSENT**
• I give this practice/ clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.
• I give this practice consent to leave messages with household members and answering machines when necessary.
• I have been informed that I may review the practice's "Notice of Privacy Practices" (https://jeffkindseth.blob.core.windows.net/content/docs/PrivacyPractices.pdf) (for a more complete description of uses and disclosures) before signing this consent.
• I understand that this practice has the right to change their Privacy Practices and that I may obtain any revised notices at the practice.
• I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow restriction(s).
• I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/ or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

________________ ________________
Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

Medical Updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS