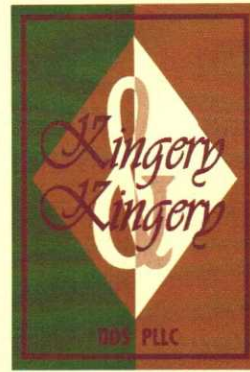


Welcome!

Our goal is to make every patient's visit pleasant and educational. We believe in preventive maintenance; therefore we teach good home oral care so you and your child may enjoy a beautiful smile for a lifetime. The more we know about you and your child, the better we can assist both of you. Thank you.



Warm Hearts, Beautiful Smiles

William H. Kingery, DDS
Mary E. Kingery, DDS

2554 Lewisville-Clemmons Rd
Clemmons, NC 27012
336.766.0511 (phone)
336.766.7390 (fax)
kingerysmiles.com

About your child

Child's name _____ Nickname _____
Child's birthdate _____ School _____ Grade _____
Child's home# _____ SS# _____
Child's home address _____
Street/Apt/Condo _____ City _____ State _____ Zip _____

Who is accompanying your child?

Name _____ Relationship to child _____
Do you have legal custody of the child? _____ Whom may we thank for referring you? _____
Other family members seen by us? _____
In case of emergency, contact _____
Previous dentist _____ Last visit date _____
Parent's marital status (circle): Single Married Divorced Separated Widowed

*Please note that the parent or guardian accompanying the child today will be listed as the responsible party regardless of insurance or marital status unless signed written consent or legal documentation is presented.

Parent information

Mother's name _____ Home# _____ Work# _____
Employer _____ Occupation _____
SS# _____ Driver's license# _____
Father's name _____ Home# _____ Work# _____
Employer _____ Occupation _____
SS# _____ Driver's license# _____

Primary insurance

Insurance co. name _____ Insured's name _____
Insurance co. address _____
Phone# _____ Group# _____ Relationship to patient _____
Insured's employer _____ Insured's birthdate _____

More about you

Why are you visiting the dentist today? _____

Y N Have you ever had a serious/difficult problem associated with previous dental work? Please explain _____

Y N Has there been any injury/trauma to the teeth? Please explain _____

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? _____

Y N Do you floss daily? How often? _____

Your current physical health is (circle): Good Fair Poor

Physician _____ Phone# _____ Last visit date _____

Y N Do you smoke/use tobacco in any form? Y N Do you use alcohol, cocaine/other drugs?

Y N Have you ever taken Fen-Phen/Redux?

Please list all drugs that you are currently taking _____

Women:

Y N Are you pregnant/do you think you may be pregnant? Y N Do you take birth control pills? (please name) _____

Are you/have you ever had an allergic reaction to:

Y N Aspirin Y N Iodine Y N Penicillin/other antibiotics Y N Other _____

Y N Barbiturates/Sedatives Y N Local anesthetics Y N Sulfa drugs _____

Do you have/have you ever had the following:

Y N Fainting spells/seizure Y N Heart attack Y N Low blood pressure Y N Stroke

Y N Heart trouble Y N Heart surgery Y N Lung/breathing problems Y N Other _____

If you answered yes to heart attack/heart surgery, please explain _____

Have you experienced any of the following medical conditions?

Y N Abnormal bleeding Y N Convulsions/epilepsy Y N HIV+/AIDS Y N Replacement joints/implants

Y N Anemia Y N Diabetes Y N Hospital stays Y N Tuberculosis (TB)

Y N Asthma Y N Frequent nose bleeds Y N Kidney/liver problems Y N Other _____

Y N Blood transfusions Y N Handicap/disabilities Y N Latex allergies Y N Mitral valve prolapse _____

Y N Blood clots Y N Hearing impairment Y N Operations _____

Y N Brain injury Y N Heart murmur Y N Pregnancy _____

Y N Cancer Y N Hemophilia Y N Rheumatic fever _____

Y N Congenital heart defect Y N Hepatitis _____

If yes to any of the above, please explain _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. I also authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of parent or guardian _____

Date _____