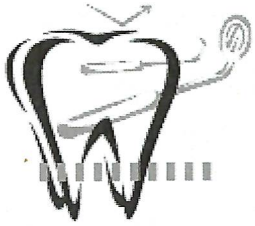

KEVIN BONE, D.D.S.

WELCOME TO OUR PRACTICE

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

First Name_____ Middle Initial_____ Last Name_____
Preferred Name (nickname, etc.)_____ Male_____ Female_____
Address_____ City_____ State_____ Zip_____
Phone Number (____) _____-_____ Work (____) _____-_____
Date of Birth _____ Social Security Number _____
Email _____
Employer _____ Occupation _____
Spouse's Name _____ Spouse's Employer _____
Whom May We Thank For Referring You? _____
If patient is a minor, name of parent or legal guardian and relationship_____

Dental Insurance Information

Primary Carrier		Secondary Carrier	
Insurance Co. Name	_____	Insurance Co. Name	_____
Group Number	_____	Group Number	_____
ID Number	_____	ID Number	_____
Insured's Name	_____	Insured's Name	_____
Insured's DOB	_____	Insured's DOB	_____
Employer	_____	Employer	_____

Person to Contact in case of Emergency

Name _____ Relationship _____
Phone Number (____) _____-_____ Work (____) _____-_____

Payment is due in full at the time of treatment

I understand that I am responsible for payment of service rendered and any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you.

Signature _____ Date_____

Dental History/Medical History

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)
Previous dentist's name _____
May we ask why you are changing dentists? _____

Indicate which of the following you have had or have at present:

Pre-Med Required	YES	NO	Marijuana	YES	NO	Epilepsy	YES	NO
Joint Replacement	YES	NO	Arthritis/Rheumatism	YES	NO	Migraines	YES	NO
Breast Implants	YES	NO	Blood Disease	YES	NO	Dementia/Alzh.	YES	NO
Heart (Surgery/disease/attack)	YES	NO	Abnormal Bleeding	YES	NO	Night Sweats	YES	NO
Pacemaker	YES	NO	Blood Transfusion	YES	NO	Hormone Therapy	YES	NO
Artificial Heart Valve	YES	NO	Anemia	YES	NO	Osteoporosis	YES	NO
Heart Murmur	YES	NO	Bruise Easily	YES	NO	Rheumatic Fever	YES	NO
Stroke	YES	NO	Auto-Immune Disorder	YES	NO	Scarlet Fever	YES	NO
Chest Pain	YES	NO	Cancer/Chemo	YES	NO	Shingles	YES	NO
Angina	YES	NO	Radiation Therapy	YES	NO	Sickle Cell	YES	NO
Mitral Valve Prolapse	YES	NO	Cold Sores/Herpes	YES	NO	Snoring	YES	NO
Allergies/Hives	YES	NO	Chicken Pox	YES	NO	Sleep Apnea	YES	NO
Sinus Trouble	YES	NO	Dry Mouth	YES	NO	Stomach Problems	YES	NO
Asthma	YES	NO	Diabetes	YES	NO	Colitis	YES	NO
Difficulty Breathing	YES	NO	Fainting Dizzy Spells	YES	NO	Ulcers	YES	NO
Emphysema	YES	NO	Glaucoma	YES	NO	Thyroid Problems	YES	NO
Anxiety	YES	NO	Liver Disease	YES	NO	Tumors	YES	NO
Aids/HIV	YES	NO	Hepatitus - A, B, C	YES	NO	Tuberculosis	YES	NO
Alcohol Addiction	YES	NO	High Blood Pressure	YES	NO	Venereal Dis./STD	YES	NO
Drug Addiction	YES	NO	Low Blood Pressure	YES	NO	Birth Control	YES	NO
Eating Disorder	YES	NO	Kidney Trouble	YES	NO	Pregnant	YES	NO
Tobacco-smoke/vape/chew	YES	NO	Neurological Disorders	YES	NO	Nursing	YES	NO

Surgery: Please list with year YES NO _____

_____

Cancer: Please list with year YES NO _____

_____

Please list any serious medical condition(s) that you have ever had not listed above: _____
Are you aware of having an allergic (or adverse) reaction to any of the following?

Aspirin	YES	NO	Iodine	YES	NO	Codeine	YES	NO
Metals	YES	NO	Sulfa Drugs	YES	NO	Anesthetics	YES	NO
Latex	YES	NO	Penicillin	YES	NO	Other Antibiotics	YES	NO

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ____yes ____no
If yes, for what? _____

_____

Physicians name _____ Phone Number (___) _____-_____
Are you currently taking any medications or drugs? _____yes _____no
If yes, please list: _____

_____

_____

Patient Signature _____ Date _____

All information is protected by Doctor-Patient Confidentiality. You will be held responsible if statements are untrue.