Edward L. Kircher DDS

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Patient Information

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________* ____________* ____ ____________
Last First M Preferred Name

Title: ________ (Mr/Ms/Mrs/etc) **Gender:*** ○ Male ○ Female **Family Status:*** ○ Married ○ Single ○ Child ○ Other

Birth Date:* ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

Email Address: ____________________ **Best time to call:** ____________

Phone: ____________* ____________ ____________ ______ ____________ ____________
Home Mobile Work Ext Fax Other

Address: ____________________* ____________________
Address 1 Address 2

____________________* ______* _____-____*
City State Zip Code

Referral Information

Name of person, office or other source referring you to our practice:

____

Spouse or Responsible Party Information

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Patient Name: ____________ ____________ ____ ____________
Last First M Preferred Name

Employment Information

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: ____________________ **Phone:** ____________

Employer Address: ____________________ ____________________
Address 1 Address 2

____________________ ______ _____-____
City State Zip Code

Insurance Information

Name of Insured: ______________________ ______________________ ___
Last First M

Insured's Birth Date: __________ **ID #:** ______________ **Group #:** ______________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ ____-____
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ ____-____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ______________________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ ____-____
City State Zip Code

Secondary Dental

Name of Insured: ______________________ ______________________ ___
Last First M

Insured's Birth Date: __________ **ID #:** ______________ **Group #:** ______________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ ____-____
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ ____-____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ______________________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ ____-____
City State Zip Code

Are you in good health? * ○ Yes ○ No

Are you now under the care of a physician? * ○ Yes ○ No

Have you been hospitalized in the last five years? * ○ Yes ○ No

Are you taking any medications, including non-prescription? * ○ Yes ○ No

Do you have a heart murmur or rheumatic heart disease? * ○ Yes ○ No

Do you have cardiovascular disease? * ○ Yes ○ No

Do you have high blood pressure? * ○ Yes ○ No

Do you have any known allergies? * ○ Yes ○ No

Do you have problems with seizures or fainting spells? * ○ Yes ○ No

Do you have diabetes? * ○ Yes ○ No

Have you had hepatitis, jaundice, or liver disease? * ○ Yes ○ No

Do you have HIV infection or AIDS? * ○ Yes ○ No

Have you had thyroid problems? ○ Yes ○ No

Have you had respiratory problems or asthma? * ○ Yes ○ No

Have you had arthritis or painful swollen joints? * ○ Yes ○ No

Have you had ulcers or stomach acidity problems? * ○ Yes ○ No

Have you had kidney problems? * ○ Yes ○ No

Have you had tuberculosis? * ○ Yes ○ No

Do you have a persistent cough or cough that produces blood? * ○ Yes ○ No

Do you have persistent swollen glands in the neck? ○ Yes ○ No

Do you have low blood pressure? * ○ Yes ○ No

Have you had a sexually transmitted disease? * ○ Yes ○ No

Do you have epilepsy or other neurological disease? * ○ Yes ○ No

Do you have any problems with your mental health? * ○ Yes ○ No

Have you had problems with your immune system? * ○ Yes ○ No

Have you had abnormal bleeding or a blood transfusion? * ○ Yes ○ No

Do you have anemia? * ○ Yes ○ No

Have you ever had treatment for a tumor or growth? * ○ Yes ○ No

Are you allergic to local anesthetics? * ○ Yes ○ No

Are you allergic to penicillin or any other antibiotics? * ○ Yes ○ No

Are you allergic to sulfa drugs? * ○ Yes ○ No

Are you allergic to barbiturates or sedatives? * ○ Yes ○ No

Are you allergic to iodine? * ○ Yes ○ No

Are you allergic to Codeine? * ○ Yes ○ No

Are you allergic to latex? * ○ Yes ○ No

Do you have any other known allergies to medications? * ○ Yes ○ No

Have you had any trouble associated with dental treatment? * ○ Yes ○ No

Are you pregnant? * ○ Yes ○ No

Are you nursing? * ○ Yes ○ No

Are you taking birth control pills? * ○ Yes ○ No

Have you ever had a joint replacement. * ○ Yes ○ No

Do you have any condition not listed: *

____

____

Medications you are presently taking (this includes prescription, over the counter, and inhalers): *

____

____

Pharmacy Name: *

____

____

In case of emergency, Please notify: *

____

____

Phone: *

____

____

Physician's Name: *

____

____

Patient Signature and Date

Signature ____ **Date** __________

Response Date: ____/____/________