" Fewer shots, Less pain, Superior results."

Kelly R. Clarke, DDS, PLLC
706 39th Street West
Bradenton, Florida 34205
941-748-0660
www.laserdentistryonline.com

WELCOME!

So we may provide you with the best possible care and get to know you better, please complete these personal information, medical & dental history forms. All information is confidential.

Date: _____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Preferred to be called: _____

Name: First _____ Last _____ MI_____

Residence _____

City _____ State _____ Zip_____

Secondary Residence: _____

City _____ State _____ Zip_____

Home Phone: _____ Work:_____

Cell: _____

E-mail address_____ Date of birth: _____/_____/_____.

Social Security # _____ Sex: M F Marital Status: _____

How were you referred to our office? Family/Friend:_____ Who: _____
Sign _____ Other _____
Yellow Pages/Phone Book:_____

Personal Interests: _____

Physician's name:_____Phone: _____

Date of last visit: _____ Pharmacy: _____ Phone: _____

In case of emergency, contact: _____ Phone: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Spouse's Name: _____ Occupation: _____

Spouse's Employer _____ Work Phone:_____

INSURANCE INFORMATION

Do you have dental insurance? Yes or No **Please present your insurance card.**

Insured's Name: _____ Employer's Name: _____

Insured's Social Security # _____ Date of birth: _____/_____/_____.

Insurance Company:_____ Group #: _____

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PATIENT MEDICAL HISTORY

General Questions. This questionnaire will be used by your dentist to help treat you safely. Please answer all questions as accurately as possible.

Indicate which of the following you have had or have at present. Circle **YES** or **NO**

Arthritis/Rheumatism	Yes	No
Artificial Joints	Yes	No
Artificial Heart Valve	Yes	No
Acid Reflux	Yes	No
Asthma	Yes	No
AIDS/HIV	Yes	No
Bad Breath/Bleeding gums	Yes	No
Congenital Heart Disease	Yes	No
Cancer	Yes	No
C-Pap/Sleep Apnea	Yes	No
Cold Sore/Fever blisters	Yes	No
Chemo/Radiation	Yes	No
Diabetes	Yes	No
Dementia/Alzheimers	Yes	No
Dry mouth	Yes	No
Drug/Alcohol Abuse	Yes	No
Epilepsy/Seizures	Yes	No
Heart Murmur	Yes	No
Heart Mitral Valve Prolapse	Yes	No

Heart Pacemaker	Yes	No
Hepatitis, Type ____	Yes	No
High Blood Pressure	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Osteoporosis	Yes	No
Pregnant/Nursing	Yes	No
Psychiatric Care	Yes	No
Sjogrens Syndrome	Yes	No
Snore Problems	Yes	No
Smoke/Chew Tobacco	Yes	No
Taking blood thinners?	Yes	No
Thyroid Disease	Yes	No
Pre-medicate for dental appts	Yes	No
Are you happy with your smile?	Yes	No
What would you change? _____		
_____		
Tooth pain or sensitivity?	Yes	No
Where? _____		

Other: _____

List any food or medication allergy_____

Have you ever taken an appetite suppressant? (Such as Fen-Phen)	Yes	No	
Have you ever taken Bisphosphonate medication? (Such as Fosamax)	Yes	No	
Do you smoke tobacco?	Yes	No	How much do you smoke?
Do you use alcohol?	Yes	No	How many drinks per week?
Do you use recreational drugs?	Yes	No	What type?
			Last recreational drug use?
For women only: Do you believe you are presently pregnant?	Yes	No	
Are you currently taking Birth Control Pills?	Yes	No	

Please list any allergies:

_____
_____
_____
_____
_____
_____

Please list any medications:

_____
_____
_____
_____
_____
_____

Doctors notes:

_____
_____
_____
_____
_____
_____

Consent for Treatment

I, hereby authorize doctor or designated staff to take x-rays, impressions, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I or my dependents agree to be responsible for payment of all services rendered on my behalf. I understand that payment is due at the time of service.

Patient's signature:_____Date: _____

Guarantor's signature: _____Date: _____

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DENTAL HISTORY AND SMILE ANALYSIS

When was your last dental appointment? _____

When was your last dental cleaning? _____ Dental X-rays? _____

Are you having any problems at this time? _____

Are your teeth sensitive to any of the following? (please circle)

Heat Cold Sweets Biting

Please circle Yes or No for the following:

Have you ever been told you have gum disease?	Yes	No
Do Your gums bleed when you brush?	Yes	No
Do you have an unpleasant taste or odor in your mouth?	Yes	No
Discomfort, popping, clicking or locking of your jaw?	Yes	No
Pain upon chewing, opening wide or yawning?	Yes	No
Grinding or clenching your teeth?	Yes	No
Frequent headaches, neck or shoulder aches?	Yes	No
Loose teeth or changes in your bite?	Yes	No
Do you have a night guard?	Yes	No

On a scale from 1-10 (10 being best) how would you rate your:

Dental Health: _____ Your Smile: _____

Is there anything that concerns you about your smile? (color, spaces, chips, unsightly crowns or restorations, etc...) _____

Do you have any concerns about your old fillings or restorations? _____

If possible, would you like whiter teeth? _____

Why did you leave your last dentist? _____

_____

Name _____ Date _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Dr. Kelly R. Clarke, this ____ day of _____, 20___. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
Please print your name

_____
Please sign your name

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority _____ .

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer.

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment ____

I could not communicate with the patient ____

The patient refused to sign ____

The patient was unable to sign because ____

Other (please describe) ____

_____
Signature of privacy officer