**Kenneth E. Kay, DMD, LLC**
**Dental Registration and History**

| **Patient Information:** | | |
|---|---|---|
| Last Name: | First Name: | Middle Name: |
| Home Phone: | Cell #: | Work #: |
| Email address: | SS#: | |
| Address (street/city/state/zip): | | |
| Date of birth: | Gender: | Occupation: |
| Spouse/parent name: | Spouse/parent DOB: | Spouse/parent SS#: |
| Emergency contact name: | Relationship: | Phone: |

If you are completing this form for another person, what is your name and relationship to this person? Name: ________________________ Relationship: _______________________ If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedures on this patient. I will immediately notify the practice in writing if I am no longer the legal representative. Signature: ________________________________________________________________

| **Dental History and Symptoms:** | |
|---|---|
| What is the reason for your visit today: | |
| Are you currently experiencing any dental pain or discomfort: | If yes, where? |
| When was your last dental exam: | What was done at that appt: |
| When was the last time you had dental xrays: | |

**Please mark an "x" in the boxes below ONLY if it applies to you.**

| | **Yes** | | **Yes** |
|---|---|---|---|
| Is it hard to open your mouth? | | Have you ever seriously injured your head/mouth? | |
| Does it hurt to chew/bite/swallow? | | Please describe the injury:____________________________ | |
| Do your gums bleed when you brush or floss? | | | |
| Have you ever had periodontal (gum) treatments like scaling and root planning or surgery? | | Have you had problems with dental treatment in the past? | |
| Do you have/have ever had sores or growths in your mouth? | | Have you had problems with dental anesthesia in the past? | |
| Do you clench or grind your teeth? | | Please describe the problem:____________________ | |
| Does your jaw click, pop or hurt? | | Are you unhappy with your smile? | |
| Do you have earaches or neck pain? | | Have you ever had any sleep related breathing disorders like apnea, mouth breathing, snoring? | |
| Does going to the dentist make you scared or nervous? | | | |

**Please list all medications you are currently taking (including supplements, and over the counter medications):**

| |
|---|
| |
| |
| |
| |

| **Medications and Other Products and Substances** (Please use an "X" to mark your answers) | **Yes** | **No** |
|---|---|---|
| **Are you taking any blood thinners** (such as coumadin, warfarin, Xarelto, Pradaxa, Plavix, heparin, aspirin, etc)<br>If yes, which one? | | |
| **Do you bleed easily/heavily or bruise easily?** | | |
| **Are you taking drugs to treat osteoporosis, Paget's disease, osteopenia, or any other drugs to help strengthen bones? If yes, which one ( Examples: Boniva, Fosomax, Actonel, Reclast, Prolia, etc.)?** | | |
| Are you taking or scheduled to take an IV medication to treat cancer, bone pain, hypercalcemia, or bone loss?<br>If yes, which one? | | |
| Are you taking hormone replacement medications or birth control pills? | | |
| **Do you use any form of tobacco products?** (smoking, vaping, snuff, chew, cigars )<br>If yes, for how long/often? | | |
| Do you use vaping products?<br>If yes, how long/often? | | |
| Do you drink alcohol?<br>If yes, how many per week? | | |
| Do you use opioids or other controlled substances?<br>If yes, which ones and how often? | | |
| Women: Are you pregnant? If yes, number of weeks: | | |
| Are you nursing? If yes, number of weeks: | | |

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| **Medical History:** | | |
|---|---|---|
| Date of last Physical exam: What is your normal blood pressure: | | |
| Doctor's Name/phone: | | |
| **Please use an "x" to mark your answers to the following questions:** | **Yes** | **No** |
| Are you in good physical health? | | |
| Has a physician or dentist recommended that you take antibiotics before dental work? | | |
| Have you had a serious illness/been hospitalized in the past 5 years? | | |
| Have you had joint replacement surgery? | | |
| Have you had a heart valve replaced or heart surgery? | | |
| Have you had an organ or bone marrow/stem cell transplant? | | |
| Have you had a fever in the past 72 hours? | | |
| If you answered yes to any of these questions, please explain: | | |

**Do you have, or have you had, any of the following conditions:**

| **Heart** | **Yes** | **No** | **Blood/Circulatory health** | **Yes** | **No** | **Cancer** | **Yes** | **No** |
|---|---|---|---|---|---|---|---|---|
| Pacemaker/ defibrillator | | | Anemia | | | Cancer diagnosis? | | |
| Artificial heart valve | | | Transfusion (Date: ) | | | Date of diagnosis | | |
| Infective endocarditis | | | Hemophilia | | | Chemo? | | |
| Congenital heart disease | | | High or low blood pressure? | | | Radiation? | | |
| Arteriosclerosis | | | **Brain/Neurological** | | | **Eye** | | |
| Coronary Artery Disease | | | Anxiety | | | Glaucoma | | |
| Congestive heart failure | | | Depression | | | **Other conditions** | | |
| Damaged heart valves | | | Epilepsy | | | Chronic pain | | |
| Heart attack | | | Mental Health issues | | | Diabetes (Type I or II) | | |
| Heart murmur | | | Neurological disorders | | | Hepatitis (Type: ) | | |
| Afib | | | Migraine | | | Liver disease | | |
| Rheumatic heart disease | | | PTSD | | | Kidney Problems | | |
| Stroke | | | TBI or concussion | | | Thyroid problems | | |
| **Breathing** | | | **Digestive Health** | | | Frequent infections | | |
| Asthma/COPD | | | Reflux/heartburn | | | HIV/AIDS | | |
| Bronchitis | | | Stomach ulcers | | | Osteoporosis/osteopenia | | |
| Emphysema | | | Gastrointestinal disease | | | Malnutrition | | |
| Sinus problems | | | | | | Fainting/falls | | |
| TB | | | | | | Autoimmune disease | | |
| | | | | | | Sexually transmitted infection | | |
| | | | | | | Arthritis | | |
| | | | | | | | | |

| **Allergies: Are you allergic or have you had a reaction to: (Please use an "x" to mark your answers)** | **Yes** | **No** | **?** |
|---|---|---|---|
| Penicillin or other antibiotics Which ones: | | | |
| Latex | | | |
| Local anesthetic or epinephrine | | | |
| Barbituates/sedatives/anxiety meds, or sleeping pills | | | |
| Sulfa drugs (Septra, Bactrim, etc.) | | | |
| Aspirin or other NSAIDS | | | |
| Iodine | | | |
| Seasonal allergies/hay fever | | | |
| Other? Please list: | | | |

**I have answered the questions above completely and accurately and I understand I must tell my dentist about any changes in my medical condition.**

Signature: Date: