Richard Kitt DDS, PA

PATIENT INFORMATION FORM

In order that we may better serve you, please complete in full

Today's Date: _______/______/2017 Date of Birth: ______/______/______

Name ____ Sex ___M ___F

Single Married Divorced Widowed

Address______________________________City____________State____ Zip_______

E-mail ____

Home# (____) _____-_____ Cell# (____) _____-_____ Work# (____) _____-_____

Do you Text ____Y ___N

Spouse's/Partner's Name__________________________Contact#______________

Place of Employment: ____

Are You a Seasonal Resident? ___Y ___N From __________ To __________

Who is responsible for your account_________________________________

Emergency Contact__________________ Relationship________ Phone#______________

Whom may we thank for referring you to our office?__________________________

DENTAL HISTORY

Chief Oral Complaint ____

Date of last cleaning ________ Do your gums bleed when you brush or floss ___Y __N

How frequently do you have dental cleanings ____________________

Have you ever been treated for Periodontal Disease ____Y ____N

Orthodontic Treatment ____Y ___N

Teeth Sensitive to Cold, Heat, Sweets or Pressure ____Y ____N

Bad Breath ____Y ____N

Clinching or Grinding ____Y ____N

Unfavorable Dental Experience ____Y ____N Explanation____________________

Complications from Extractions ____Y ____N

Cigarettes, Pipe or Cigar Smoking ____Y ____N

MEDICAL HISTORY

NAME____**DATE** _____/______/2017

Have you been told that you need to PREMEDICATE or take antibiotics prior to a dental procedure? _ Y _ N
Which antibiotic do you take? __________________________ For What condition? _______________________

Please circle indicating that you have taken or are taking the following: Fosamax, Zometa, Didronel, Reclast, Boniva, Atelvia, Aclasta, Actonel, Binosto, or other ____________________________

MEDICATIONS

List all medications you are currently taking

Drug____________________	Drug____________________	Drug____________________
Drug____________________	Drug____________________	Drug____________________
Drug____________________	Drug____________________	Drug____________________
Drug____________________	Drug____________________	Drug____________________

ALLERGIES

Local Anesthetics	__Y __N	Codeine or other Narcotics	__Y __N
Aspirin	__Y __N	Latex	__Y __N
Penicillin or other Antibiotics	__Y __N	Iodine	__Y __N
Sulfa Drugs	__Y __N	Other________________________	

MEDICAL INFORMATION

Please circle indicating that you have had the following:

Abnormal Bleeding	Hepatitis	Stomach Ulcer/Hyperacidity
Anemia	Herpes	Stroke
Are you on blood thinners	High or Low Blood Pressure	Sjorgren's Syndrome
Blood Disease Tuberculosis	HIV/AIDS	Tuberculosis
Cancer (type)________________	Joint Replacement (knee, hip, ect)	Valve Replacement
Diabetes	Kidney Disease	
Do you smoke	Liver Disease	
Emphysema	Neck/Back Problems	
Epilepsy/Seizure	Pacemaker/Defibrillator	
Glaucoma	Previous Endocarditis	
Eye Surgery or Procedure	Radiation Therapy	
Heart Defect	Rheumatic or Scarlet Fever	
Heart Murmur/Leaky Valve	Sinus Infection	

PHYSICIAN'S NAME: ______________________________________ **PHONE # (____) ______- ______**

Do you have any disease, condition, or medical problem not listed above that you think we should know about? Please explain:

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I certify that I have read and understand the above. I have received a copy of Dr. Richard Kitt Notice of Privacy Practice. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or and other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: ______________________________________ Date: _____/______/2017