Date: _____________

Updated Health Information

Kennerly Dental Group, Inc.

Patient Name: ____ Date:____________________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other____________________

Social Security #: ____________________ Birth Date:___________ E-Mail:______________________________

Phone (Home): __________________ (Work): __________________ Ext:______ (Cell):______________________

Address: ____
Street Apartment #

____
City State Zip Code

Emergency contact: ______________________________ Phone #: ______________________________

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Anemia
☐ Arthritis
☐ Artificial Joints/Valves
☐ Asthma
☐ Blood Disease
☐ Cancer- Type ______
☐ Diabetes-Type 1 or 2
☐ Dizziness/Fainting
☐ Epilepsy
☐ Excessive Bleeding
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis A-B-C
☐ High Blood Pressure
☐ HPV- Type ________
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Oral Lesions/Lumps
☐ Pacemaker
☐ Pregnancy
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sexual Transmitted
Diseases- ________
☐ Sinus Problems
☐ Spinal/Back Issues
☐ Stomach Problems
☐ Stroke
☐ Surgical Stents
☐ Tuberculosis
☐ Tumors/Growths
☐ Ulcers

ALLERGIES:
☐ Codeine
☐ Penicillin
☐ Sulfa Drugs
☐ Latex

Other Allergies:
☐ _________________

MEDICATIONS CURRENTLY TAKING:
____
____
____
____

● If any of the above disorders are checked or not listed, please explain in detail:
____
____
____

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:____
• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:____
• Are you now under the care of a physician? ☐ Yes ☐ No Date of last visit____________________
If yes, please explain:____
• Name of Physician: ____ Phone:______________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

________________________________ Date: _____________ Relationship to Patient:
Signature of patient, parent or guardian

Employment Information

(If there has been no change in employment status check next to "SAME") ☐ **SAME**

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____ Phone: ______________________________

Address: ____
Street City State Zip Code

Dental Insurance Information

(Patients are ultimately responsible for understanding their insurance coverage/benefits and informing Kennerly Dental of any changes)

Primary (If there has been no change in primary insurance check next to "SAME") ☐ **SAME**

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ SS #: ______________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ______________________________ Phone ______________

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ____

Secondary (If there has been no change in secondary insurance check next to "SAME") ☐ **SAME**

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ SS #: ______________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ______________________________ Phone ______________

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ____