WELCOME
WARREN S. KAGGEN, D.D.S., FAGD

Today's Date:____________ Birth date:________________

Name:_____________________________ Date of last dental visit:___________.
Mr.Mrs.Ms.Dr.

I prefer to be called:_________________ Referred by(Whom may we thank):_________.

Home address:____.
Zip Code

Email address:_________________________ Social Security #:____________________.

Occupation:________________________ Employer:_________________________________.

Married Single Widowed Divorced

Spouse:______________________. Other family members seen by us: ______________.

Home Phone: __________________________ Work Phone( ) __________________.

Cell Phone:__________________________ Spouse work phone:___________________.

When is the best time to reach you? _________________Where?____________________.

In the event of an emergency, Whom should we contact ___________Phone#_____________.

INSURANCE

Insured: Self___________ Spouse_________ Parent_____________

Insurance Company:___________________________ group #(or name)____________________.

IF THIS SPOUSE'S PLAN or IF SPOUSE HAS A SECONDARY PLAN:

Spouse's employer:____________________.

Spouse's social security #:____________________.

Spouse's Birthday:____________________________.

Insurance Co. name & Group# of Secondary Plan:____

____.

Person responsible for account:____.

I understand that I am responsible for payment for dental services provided in this office, due at time services are rendered, unless other written arrangements are made. I fully understand that I am responsible for any balance not paid by my insurance company. Additionally, I understand that finance charges and collection fees may be charged for any account not paid within 90 days.

Please sign that You've read above: ____

Why have you come to the dentist today? ________________________________

________________________________.

Are you concerned about bad breath? Yes___ No___ Any discomfort, clicking, or popping in jaw? Yes____No_____.

Have you ever had a serious/ difficult problem dental treatment (including anxiety)? _______

________________________________.

Do you like your smile? (If not, then what would you change if you could?)_______

________________________________.

Name of Physician:____________________ Phone # ________________________.

List all medications you have taken recently, both prescription and non- prescription:_______

________________________________.

Any known allergies including medications: ________________________________

________________________________.

List any hospitalizations or surgeries:________________________________

________________________________.

List any ailment or condition you are presently being treated for:____________________

________________________________.

Have you had any serious medical problems in the past 5 years? No____ Yes___(explain):__

________________________________.

Have you ever had any of the following :

Yes No Latex or metal allergy
Yes No Diabetes
Yes No High blood pressure
Yes No artificial heart valve replacement
Yes No Hepatitis
Yes No Anxiety or Depression
Yes No Tuberculosis
Yes No Kidney/ liver problems
Yes No Sexually transmitted disease
Yes No Asthma
Yes No Prosthetic replacements (such as heart valve, hip, or knee)
Yes No Do you smoke? (How long ?)______

Yes No Birth control pills
Yes No Drug/ alcohol abuse
Yes No Heart attack /stroke
Yes No Heart condition or surgery
Yes No Pregnant
Yes No AIDS/ HIV
Yes No Sinus problems
Yes No Seizure disorder
Yes No Anemia/bleeding problems
Yes No Thyroid problem
Yes No Any medication for Osteoperosis?

I understand that the information given today is correct to the best of my knowledge and that this information will be held in the strictest confidence. I authorize release of information to process dental claims. I authorize the dental Staff to perform any necessary dental services that I may need during diagnosis and to perform all recommended treatment mutually agreed upon by me. I am responsible for advising this office of any changes in information reported on this form.

Signature__________________________ **Date:**________________ **Thank You!!**