Keene Dental Care
Johnathan Mallott, D.D.S.

811 N. Keene Street
Columbia, MO 65201

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home Phone _____
Cell Phone _____ Business Phone _____
Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address *(if different from patient)* _____ Home Phone _____
City _____ State _____ Zip _____
Cell Phone _____ Email _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address *(if different from patient)* _____ Soc. Sec. # _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Subscriber Employed by _____ Business Phone _____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Dental History

Are you in dental discomfort today?_____ What would you like us to do today?_____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of Last Dental Care _____ Date of Last X-Rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad Breath	❑ Y ❑ N Food collection between teeth	❑ Y ❑ N Periodontal treatment	❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Bleeding	❑ Y ❑ N Grinding or clenching teeth	❑ Y ❑ N Sensitivity to cold	❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Clicking or popping jaw	❑ Y ❑ N Loose teeth or broken fillings	❑ Y ❑ N Sensitivity to hot	❑ Y ❑ N Sores or growths in mouth

How often do you brush?_____ Floss?_____

Would you like to change the appearance of your teeth?_____ If so, how?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Medical physician's name _____ Phone_____

Date of last visit _____ Have you ever had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N Have you been told that you need to be pre-medicated before dental treatment? ❑ Y ❑ N

Women: are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes if you have had any of the following:

❑ Y AIDS/HIV Positive	❑ Y Cough, persistent	❑ Y Jaw pain	❑ Y Shingles
❑ Y Anaphylaxis	❑ Y Cough up blood	❑ Y Kidney disease/malfunction	❑ Y Shortness of breath
❑ Y Anemia	❑ Y Diabetes	❑ Y Liver disease	❑ Y Skin rash
❑ Y Arthritis, Rheumatism	❑ Y Epilepsy	❑ Y Material allergies (latex,	❑ Y Spina Bifida
❑ Y Artificial heart valves	❑ Y Fainting	wood, metal, chemicals)	❑ Y Stroke
❑ Y Artificial joints	❑ Y Food Allergies	❑ Y Mitral valve prolapse	❑ Y Surgical implant
❑ Y Asthma	❑ Y Glaucoma	❑ Y Nervous problems	❑ Y Swelling of feet or ankles
❑ Y Atopic (allergy prone)	❑ Y Headaches	❑ Y Pacemaker/heart surgery	❑ Y Thyroid disease/malfunction
❑ Y Back problems	❑ Y Heart murmur	❑ Y Psychiatric care	❑ Y Tobacco habit
❑ Y Blood disease	❑ Y Heart problems	❑ Y Rapid weight gain or loss	❑ Y Tonsilitis
❑ Y Cancer	Describe_____	❑ Y Radiation treatment	❑ Y Tuberculosis
❑ Y Chemical dependency	❑ Y Hemophilia/Abnormal Bleeding	❑ Y Respiratory disease	❑ Y Ulcer/Colitis
❑ Y Chemotherapy	❑ Y Herpes (oral, other)	❑ Y Rheumatic/scarlet fever	❑ Y STD
❑ Y Circulatory problems	❑ Y Hepatitis (type_____)	❑ Y Osteoporosis or other bone	
❑ Y Cortisone treatments	❑ Y High blood pressure	disorders	

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

- I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.
- I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. A late fee of 1.5% per month is charged on account balances over 30 days.

Signature_____ Date_____

Payment is due in full at time of treatment, unless prior arrangements have been approved, including the deductible and any estimated after-insurance balance.