Wm. B Keskimaki DDS

HEALTH HISTORY

Date _____ Patient Name _____ Name you wish to be called _____
Physical Address _____ Home Phone _____
City _____ State _____ Zip Code _____ Work Phone _____
Mailing Address _____ Cell Phone _____
City _____ State _____ Zip Code _____
Best Time and Place to Reach You Live and In Person _____
Sex: ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient SS # _____ Occupation _____ Employer _____
Employer Address _____ Employer Phone _____
Spouse Name _____ Spouse Phone _____

****

IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)
Name _____ Relationship to you _____
Address and Phone Number of Emergency Contact Person _____
Whom may we thank for referring you? _____
Who is responsible for this account? _____ Relationship to patient _____

****

Insurance Company _____ Group # _____
Is patient covered by additional insurance? ☐ yes ☐ no Subscriber's name _____
Subscriber's Birthdate _____ Subscriber's SS# _____ Relationship to Patient _____
Insurance company _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

****

DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ City/State _____
Date of last dental visit _____ Date of last dental X-rays _____
Please check Yes or No to indicate if you have had any of the following:

Bad breath	☐ Yes ☐ No	Bleeding gums	☐ Yes ☐ No	Blisters on lips or mouth	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No	Chew on one side of mouth	☐ Yes ☐ No	Cigarette, pipe or cigar smoking	☐ Yes ☐ No
Clicking or popping Jaw	☐ Yes ☐ No	Dry mouth	☐ Yes ☐ No	Fingernail biting	☐ Yes ☐ No
Do you or have you ever experienced pain/discomfort in your jaw joint	☐ Yes ☐ No	Food collection between teeth		Chewing tobacco	☐ Yes ☐ No
Food collection tender	☐ Yes ☐ No	Foreign objects	☐ Yes ☐ No	Grinding teeth	☐ Yes ☐ No
Periodontal	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No	Lip or cheek biting	☐ Yes ☐ No
Loose teeth or broken fillings	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
Pain around ear	☐ Yes ☐ No	Sensitivity to cold treatment	☐ Yes ☐ No	Gums swollen or	☐ Yes ☐ No
Sensitivity to heat	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No
Sores or growths in your mouth	☐ Yes ☐ No	How often do you floss _____		Do you like your smile	☐ Yes ☐ No
		How often do you brush?_____		Type of bristles	☐Hard ☐Medium ☐So
				Have you ever had a serious or difficult problem associated with previous dental work	☐ Yes ☐ No