

Bardstown Family Dentistry

810 Morton Avenue
Suite 200
Bardstown KY 40004-2549
(502)348-9944

tooth@bardstown.com



Welcome to our Practice

Chart #.

FOR OFFICE USE ONLY

Patient Name:
Last First MI Preferred Name

Title: Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: SS #: Prev. Visit:

Email Address: Best time to call:

Phone:
Home Work Ext Mobile Fax Other

Address:

City State Zip Code

In an emergency who should be notified? Please enter Name and Phone number:

Who may we thank for referring you to our office?

Payment is due at the time of service, as are co-pays and deductibles. How are you paying today? Thank you

Check Cash Credit Card CareCredit

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Responsible Party Information

Parent/Guardian Information:

This only needs to be filled out if insurance subscriber is other than patient, or if patient is under 18.

Relationship to patient

Self Mother Father Other

The following is for: the patient's spouse the person responsible for payment neither-not applicable

Name:
Last First MI Preferred Name

Title: Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: SS #: Driver's License #:

Email Address: Best time to call:

Phone:
Home Work Ext Mobile Fax Other

Address:

City State Zip Code

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

Employer Name: Phone:

Address:

City State Zip Code



Medical History

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> *Latex Allergy | <input type="checkbox"/> *Premed - Amox. | <input type="checkbox"/> *Premed - Clind. | <input type="checkbox"/> *Premed |
| <input type="checkbox"/> Allergic-Aspirin | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial Heart Val | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Cancer | <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Cortisone Medicine |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Erythromycin Allergy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Growths | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Methol Allergy | <input type="checkbox"/> Mitrol Valve Prolaps | <input type="checkbox"/> Morphine Allergy | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> PsychiatricTreatment | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | |

- Chemotherapy
- Headaches
- Surgical Implant
- Tobacco habit
- Have you ever been treated with medication for osteoporosis or bone cancer?
- Are you currently pregnant?

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Are you allergic to any medicines? If so, please list.

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Describe any conditions, alerts, current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all current MEDICATIONS and REASON for the medication.

By checking this box, I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Previous Dentist name and how long have you been a patient there:

Date of most recent dental exam:

What is your immediate concern?

Response Date:

Bardstown Family Dentistry Authorization Form

Patient Name _____

I authorize Bardstown Family Dentistry to discuss my dental treatment, and/or payment information with the following person / people listed below. I understand that it is my responsibility to inform the office if this information should change.

I authorize Bardstown Family Dentistry to discuss treatment regarding my child / children to the following person / people listed below.

I authorize Bardstown Family Dentistry to leave messages on my home or cell phone. Yes No

Signature: _____ Date: _____