RYAN KOHLMEIER DDS LLC

Patient Registration and Health Record

Date_____ Name_____ SSN_____

Address_____

Home #_____ Work #_____ Cell _____

Date of Birth_____Sex_____Employer_____

Emergency Contact_____ Phone #_____

⌈ Married, Spouse's Name: _____⌈ Single ⌈ Other_____

Dental Insurance Carrier (if applicable)_____

Medical Health

Name of Physician_____ Date last seen by Physician_____

List medications and reason for taking (if you have a list with you, please allow us to make a copy)

_____

_____

Please mark all that apply. Have you ever been treated for:

Heart Disease……___
High Blood Pressure…….___
Diabetes……___
Epilepsy/Seizures…….___
Congenital Heart Defects….___
Cancer……...___

Joint Replacement……___
Asthma……___
Arthritis……___
Stroke……..___
AIDS/HIV……...…___

Allergies to: Penicillin__ Codeine__ Local Anesthetics___ Other_____

Women, are you pregnant____ If so, how far along_____

Dental Health

Reason for visit:_____ Date of last dental visit_____

Have you had any problems with prior dental experiences?__ If so, please explain_____

_____

Do your gums bleed after brushing or flossing?_____

Are you currently experiencing pain or sensitivity associated with your teeth?_____

Do you have frequent headaches?_____ Do you clench or grind your teeth?_____

Please add anything else you feel is important for us to know:_____

_____

_____

_____

Thank you for giving us the opportunity to provide your dental care.