Edward D. Dallam, DDS
5000 West 95th St., Ste. 300
Prairie Village, KS 66207
(913)649-0310
www.dallamdds.com
edwarddallamdds@gmail.com

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

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

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

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

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

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

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

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DENTAL INSURANCE INFORMATION

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____

City State Zip Code

Who may we thank for referring you to our practice?

_____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

Your Primary Care Physician's name, address, & phone number:

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Please indicate if you have experienced any of the following:

- [ ] Abnormal Bleeding
- [ ] Allergies Anesthetic
- [ ] Allergies Latex
- [ ] Allergies Penicillin
- [ ] Allergies-See Notes
- [ ] Alzheimers
- [ ] Anemia
- [ ] Arthritis
- [ ] Asthma/Breathing
- [ ] Bells Palsy
- [ ] Bisphosphonates HX
- [ ] Blood Disease
- [ ] Cancer
- [ ] Chemo/Radiation Tx
- [ ] Codeine Allergy
- [ ] Coumadin
- [ ] Defibrillator
- [ ] Diabetes
- [ ] Frequent Headaches
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Heart Murmur or MVP
- [ ] Heart Trouble
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV/AIDS
- [ ] HIV
- [ ] Jaundice
- [ ] Joint Replacement
- [ ] Kidney/Bladder Troub
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Measles
- [ ] Needs N20-02
- [ ] Nervous Disorders
- [ ] No Epi
- [ ] Pacemaker
- [ ] Parkinsons
- [ ] PreMed
- [ ] Psychiatric Disorder
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] See Health History
- [ ] Seizre/Epilpsy/Faint
- [ ] Sinus Problems
- [ ] Sleep Apnea
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Allergy
- [ ] Thyroid Trouble
- [ ] Tobacco Products
- [ ] Tourette Syndrome
- [ ] Tuberculosis
- [ ] Ulcers

Please mark any of the following to indicate Yes in response to the question:

- [ ] Have you ever had complications following dental treatment?
- [ ] Are you currently under the care of a physician due to a specific condition?
- [ ] Have you been hospitalized within the last 5 years due to a surgery or illness?
- [ ] Do you use tobacco (smoking or chewing)?
- [ ] Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

WOMEN ONLY: Are you pregnant?

- ◯ Yes
- ◯ No

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Please list any medications, including over the counter, that you are currently taking.

Please list all medication and food allergies you have.

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

Prior Dentist's name, address, & phone number:

If you could change anything about your mouth, teeth, or smile, what would it be?

Please mark any of the following to indicate Yes in response to the question:

- [ ] Do your gums bleed when you brush or floss?
- [ ] Do your teeth experience sensitivity to cold or hot temperatures?
- [ ] Are any of your teeth currently causing you pain?
- [ ] Do you grind your teeth (either consciously or during sleep)?
- [ ] Are any of your teeth loose, or are you concerned about any teeth loosening?
- [ ] Do you currently have any dental implants, dentures, or partials?

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Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

I give Edward D. Dallam, DDS my permission to discuss my dental needs with my family members if needed.

* ◯ Yes ◯ No

Names of persons Edward D. Dallam, DDS is permitted to share dental information with:

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Response Date: