

JOHN M. KLEMEN, D.D.S.
 6112 N. College Avenue
 Indianapolis, IN 46220
 (317)251-0443
Dental Patient Personal/Medical History

Name _____ Nickname _____ Social Security# _____ - _____ - _____

Address _____ Zip _____

Age _____ Birth Date _____ Marital Status: W D S M Sex: M F Home Phone# _____

Business Phone# _____ Cell Phone# _____ Pager# _____

Occupation _____ Employer _____

Emergency contact: Name _____ Relationship _____ Phone# _____

Parent or Guardian _____ Address(if different) _____

Dental Insurance _____ ID# _____ Medicaid# _____

Circle any of the following, which you have had or have at present: Physicians name & phone# _____

- | | | | | |
|------------------------|----------------------|--------------------------|--------------------------|-----------------------|
| Heart Condition | Anemia or Hemophilia | Skin Rashes or Hives | Thyroid Disease | Radiation Therapy |
| Heart Attack or Stroke | Bruise Easily | Kidney Trouble | Cortisone Medicine | Chemotherapy |
| Heart Murmur | Shortness of Breath | Diabetes | Glaucoma | AIDS |
| Chest Pains (Angina) | Swelling of Ankles | Sickle Cell Disease | Arthritis or Rheumatism | Venereal Disease |
| Heart Surgery | Artificial Joint | Liver Disease | Pain in Jaw Joints | Genital Herpes |
| Artificial Heart Valve | Lung Disease | Hepatitis A (infectious) | Fainting or Dizzy Spells | Cold Sores |
| Heart Pacemaker | Emphysema | Hepatitis B (serum) | Alcoholism | Epilepsy or Seizures |
| High Blood Pressure | Tuberculosis (T.B.) | Hepatitis C | Drug Addiction | Psychiatric Treatment |
| Rheumatic Fever | Asthma or Hay Fever | Blood Transfusion | Cancer or Tumor | Yellow Jaundice |

Circle

- | | | | |
|--|--------|--|--------|
| Do you have any diseases, conditions or problems Not listed above?----- | No Yes | Do you smoke or use smokeless tobacco?----- | No Yes |
| If yes, please explain _____ | | Are you nervous or concerned about having dental work done?----- | No Yes |
| Are you presently taking any medicine or drugs? If yes, list drug, dosage, and frequency _____ | No Yes | Women: Are you pregnant now? Due Date _____ | No Yes |
| | | Do you anticipate becoming pregnant?----- | No Yes |
| Are you allergic to any medicine, drug or other Substance? ----- | No Yes | Are you practicing birth control?----- | No Yes |
| If yes, please list _____ | | Have you had any complications or problems with a previous pregnancy?----- | No Yes |
| Are you now, or have you been under the care of A medical doctor during the last two years?----- | No Yes | Dental treatment desired (circle): | |
| Have you ever been hospitalized or had surgery?-- | No Yes | Check-up Cleaning Cavities Restored Missing Teeth Replaced | |
| Have you ever had a reaction to a local anesthetic? | No Yes | Cosmetic Bonding Teeth Extracted Complete Dentures Ortho | |
| Have you had prolonged or unusual bleeding?----- | No Yes | Whitening Other _____ | |
| Have you ever had an injury or trauma to your face Or jaw?----- | No Yes | Best time for dental appointments: | |
| Have you ever had complications or illness following Dental treatment?----- | No Yes | Monday Tuesday Wednesday Thursday | |

Staff _____
 Comments: _____
 Referred by _____

Current Medications _____ Hospital _____ LDV _____ CC _____ TMJ _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my Medicines change, I will inform the Doctor of Dentistry at the next appointment without fail. I hereby agree that if my account should become past due or delinquent, I will pay any and all expenses of collection of my account, including but not limited to, collection fees, attorney fees, filing fees, court cost and interest.

Date _____
 Signature of Patient, Parent, or Guardian _____

I have received a copy of Dr. Klemen's notice of privacy policies. _____ initial (You will receive upon arrival at our office if using online form)

DYHAMODPTWSKA _____ (Staff Use) Best way to confirm: _____