Kopit Dental Care

3420 Worthington Blvd, Suite A
Frederick, MD 21704
t. 301 874 6350 | f. 301 874 6982

7810 Wormans Mill Rd, Suite D
Frederick, MD 21701
t. 301 378 2595 | f. 301 378 2729

e. info@kopitdentalcare.com
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Patient Information

Name _____ Birth Date _____ Age _____ Sex ❑ M ❑ F

Street address _____ City _____ State _____ Zip _____

Soc. Sec # _____ Home Phone _____ Cell Phone _____

E-mail Address _____ May we contact you via ❑ E-mail ❑ Text Message

Employer _____ Occupation _____ Work Phone _____

Employer Address _____

Marital Status _____ Spouse's Name _____ Spouse's Occupation _____

Whom may we thank for referring you? _____

Emergency Contact _____ Relation to Patient _____ Phone _____

Responsible Party Information

Name _____ Birth Date _____

Relation to Patient _____ Phone _____ Soc. Sec. # _____

Address (if different from patient's) _____

Employer _____ Occupation _____ Work Phone _____

Insurance Information

Insured's Name _____ Relation to Patient _____ Birth Date _____

Insurance Company Name _____ Phone _____

Insurance Company Address _____

Insured's Employer _____ Work Phone _____

Soc. Sec. # _____ Subscriber # _____ Group # _____

Will you be using any additional insurance? ❑ Yes ❑ No

Medical History

Do you have any general health problems? ❑ Yes ❑ No Please specify _____

Are you currently under physician's care? ❑ Yes ❑ No Reason _____

Name and phone of physician _____

Are you currently taking any drugs or medications? ❑ Yes ❑ No Please list _____

_____

Are you allergic to: ❑ Penicillin ❑ Codeine ❑ Latex ❑ Other

Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Check X if you have or have had any of the following:

❑ Anemia	❑ Blood Disorders	❑ Epilepsy	❑ Prolonged Bleeding
❑ Cortisone Treatments	❑ Cancer	❑ Heart Murmur	❑ Radiation Treatment
❑ Hepatitis	❑ Chemical Dependency	❑ Heart Problems	❑ Respiratory Disease
❑ Arthritis/Rheumatism	❑ Chemotherapy	❑ HIV/AIDS	❑ Rheumatic Fever
❑ Artificial Heart Valves	❑ Scarlet Fever	❑ Kidney Disease	❑ Shortness of Breath
❑ Artificial Joints	❑ Healing complications	❑ Liver Disease	❑ Stroke
❑ Asthma	❑ Cortisone Treatments	❑ Mitral Valve Prolapse	❑ Thyroid Problems
❑ High Blood Pressure	❑ Diabetes	❑ Pacemaker	❑ Tuberculosis

Signature Of Patient/Legal Guardian _____ Date _____

Kopit Dental Care

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Dental History

- ☐ Are your teeth sensitive to:
  Heat? ❑ Yes ❑ No Cold? ❑ Yes ❑ No Sweets? ❑ Yes ❑ No Biting Pressure? ❑ Yes ❑ No
- ☐ Does food constantly get stuck between certain teeth in your mouth? ❑ Yes ❑ No
- ☐ Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? ❑ Yes ❑ No
- ☐ Are you dissatisfied with your teeth in any way? ❑ Yes ❑ No
- ☐ Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc. ❑ Yes ❑ No
- ☐ Do you have any fillings that show in your front teeth? ❑ Yes ❑ No
- ☐ Do any of your fillings show when you smile? ❑ Yes ❑ No
- ☐ If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? ❑ Yes ❑ No
- ☐ Have you ever had any teeth removed? ❑ Yes ❑ No
  How long have these teeth been missing? _____
- ☐ Do your gums bleed when brushing? ❑ Yes ❑ No
- ☐ Do you ever avoid any part of the mouth while brushing? ❑ Yes ❑ No
- ☐ Have you been instructed regarding proper home care? ❑ Yes ❑ No
- ☐ Do you have an unpleasant taste or odor in your mouth? ❑ Yes ❑ No
- ☐ Do you smoke? ❑ Yes ❑ No
- ☐ Do you frequently snack between meals on sweets or chew gum? ❑ Yes ❑ No
- ☐ How often do you brush your teeth? _____
- ☐ Do you use dental floss? ❑ Yes ❑ No
  How often? _____
- ☐ Do you want to learn to control dental disease and retain your teeth? ❑ Yes ❑ No
- ☐ Has the fear of discomfort kept you from regular dental visits? ❑ Yes ❑ No
- ☐ Are you deeply concerned about the finances required to return your mouth to excellent dental health? ❑ Yes ❑ No
- ☐ When was your last dental appointment? _____
- ☐ What did you have done? _____
- ☐ How long since your last thorough examination with full mouth x-rays? _____
- ☐ What prompted you to seek dental care at this time? _____
- ☐ Why did you leave your last dentist? _____

Remarks

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