Kevin P. Kallmeyer, DDS, LLC
5765 South State Route 48, Suite 101 * Maineville, OH 45039
(513) 494-2833 * Fax (513) 494-0103

Patient Information

Name _____ Birth Date _____ Social Security # _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Email Address _____ Marital Status _____
If student, name of school/college _____ City _____ State _____
Patient or Parent/Guardian's Employer _____ Work Phone _____
Spouse or Parent/Guardian's Name _____ Employer_____ Work Phone_____
Person to Contact in Emergency _____ Phone _____
Who May We Thank For Referring You _____

Responsible Party Information

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Social Security #_____ Birth Date _____ Driver License #_____
Employer _____ Work Phone _____
Is this person currently a patient in our office? ☐Yes ☐No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is due at each appointment.

☐Cash ☐Check ☐Credit Card (Visa, MasterCard, American Express, or Discover)

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birth Date _____ Social Security #_____ Date Employed _____
Employer _____ Union/Local #_____ Work Phone _____
Work Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group #_____ ID #_____
Ins. Co. Address _____ City _____ State _____ Zip _____
Ins. Co. Phone _____ How much is your deductible? _____ Max. Annual Benefit _____

If you have additional dental insurance, please complete the following:

Name of Insured _____ Relationship to Patient _____
Birth Date _____ Social Security #_____ Date Employed _____
Employer _____ Union/Local #_____ Work Phone _____
Work Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group #_____ ID #_____
Ins. Co. Address _____ City _____ State _____ Zip _____
Ins. Co. Phone _____ How much is your deductible? _____ Max. Annual Benefit _____

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Medical History

Do you have any current health problems? Yes No
Are you under a physician's care now? Yes No
If yes, please describe _____

What medications are you currently taking?

Do you use tobacco? Yes No

WOMEN ONLY:
Are you pregnant or think you may be? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No

Are you allergic to or have you had reactions to any of the following:
Local Anesthetic Yes No
Penicillin or other Antibiotics Yes No
Sulfa Drugs Yes No
Codeine Yes No
Nitrous Oxide Yes No
Aspirin Yes No
Latex Rubber Yes No
Any metals (e.g. nickel, mercury, etc.) Yes No
Others, please list _____

Check any of the following you have had or presently have:

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Rheumatic Fever
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Angina
- ☐ Heart Pacemaker
- ☐ Prosthetics
- ☐ Anemia
- ☐ Stroke
- ☐ Kidney Trouble
- ☐ Ulcers
- ☐ AIDS/ARC/HIV
- ☐ STD's
- ☐ Hepatitis A (Infectious)
- ☐ Hepatitis B (Serum)
- ☐ Liver Disease
- ☐ Blood Transfusion
- ☐ Epilepsy or Seizures
- ☐ Psychiatric Treatment
- ☐ Glaucoma
- ☐ Cancer/Chemotherapy
- ☐ Venereal Disease
- ☐ Bruise Easily
- ☐ Emphysema
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Trouble
- ☐ Allergies or Hives
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Radiation Treatment
- ☐ Arthritis
- ☐ Cortisone Medicine
- ☐ Hemophelia
- ☐ Swelling in Joints
- ☐ Slow Healing Sores
- ☐ Nervousness
- ☐ Drug/Alcohol Addiction
- ☐ Fever Blisters

Please list any other medical conditions not listed above we should know about: _____

Primary Physician Name: _____ Phone #: _____ Location: _____

Dental History

Previous Dentist _____ Phone _____
Location _____ Date of Last Exam _____

Do your gums bleed while brushing or flossing? Yes No
Are your teeth sensitive to hot or cold? Yes No
Are your teeth sensitive to sweets? Yes No
Do you feel pain in any of your teeth? Yes No
Do you have sores in or near your mouth? Yes No
Do you have any head, neck, or jaw injuries? Yes No
Do you have frequent headaches? Yes No
Do you clench or grind your teeth? Yes No
Do you bite your lips or cheeks frequently? Yes No
Have you had difficult extractions in the past? Yes No
Have you had any prolonged bleeding following an extraction? Yes No

Have you had orthodontic treatment? Yes No
Do you wear dentures or partials? Yes No
Do you have any pain in jaw joints? Yes No
Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
Do you like your smile? Yes No

Please list any other dental concerns you would like to address:
_____
_____
_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits ortherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my designated dependents. Furthermore, I understand that should any additional collections measures be taken, I am responsible for all costs and fees accrued. I have read and understood the financial policy and I agree to all terms listed within it.

_____ _____
Signature of Patient (or parent/guardian if minor) **Date**