Dr. Kenneth R. Finn D.M.D, LLC.

Making Great Smiles Better Every Day

Welcome and thank you for choosing our dental team. We take great pleasure in applying the science and artistry of high-quality dentistry to improving the smiles and health of all of our patients to serve your dental needs! In order to best meet your needs, please carefully fill out the information below.

Personal Information

Name:_____
Nickname:_____
Address:_____
City, State, Zip:_____
Home Phone #:_____
Cell Phone #:_____
Work Phone #:_____
Email Address:_____
Employer:_____

Date of Birth:_____
Social Security#:_____
Sex: ( ) Male
( ) Female

Marital Status:
( ) Single ( ) Divorced
( ) Married ( ) Widowed
( ) Child ( ) Other

What is the reason for today's visit?_____ _____ _____
How long has it been since your last dental visit?_____

* If we can see you for a scheduled appointment sooner, would you like us to let you know? ( ) Yes ( ) No
* Who may we thank for referring you to our office, or how did you hear about us?_____
* Are you required to pre-medicate before dental appointments? ( ) Yes ( ) No
  If Yes please indicate reason for pre-medication: _____
* Emergency Contact Name and Phone #: _____

Insurance Information

_____(initials) I/We **DO NOT** have dental insurance
_____(initials) I/We DO have dental insurance (if so please continue below)

If you have dental coverage, we will file the claims for you, as a complimentary service. We do ask that the correct insurance information be provided at the time of your appointment in order for us to timely file the claim. If this information has changed, it is the patient's responsibility to update Kenneth R Finn DMD, LLC. When our insurance specialists are taking the time to help assist you in figuring out any or all patient portions for treatment, the patient portions presented or discussed are only an estimate based on information supplied by your insurance plan. Appropriate adjustments, if any, are made once the actual claim is processed. Payment for the entire fee is ultimately your responsibility. Account statements, if sent, are due on receipt.

Dental Insurance Co:_____
Dental Ins Co Phone #:_____
Subscriber Name:_____
Subscriber Employer:_____
Dental Subscriber ID #:_____
Dental Group #:_____

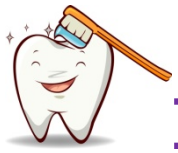
Medical Insurance Co:_____
Medical Ins Co Phone #:_____
Subscriber Name:_____
Subscriber Employer:_____
Medical Subscriber ID #:_____
Medical Group #:_____

Responsible Financial Party

Name:_____ Relationship to Patient:_____
Social Security #:_____ Date of Birth:_____
Contact Phone #: _____ Employer: _____

The above information is correct to the best of my knowledge. I agree to notify Dr. Finn's office promptly of any changes to this information.

Signature:_____ **Date:**_____



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Medical & Dental History

To help us deliver the best dental care possible, please carefully read and mark off any and all medical conditions that apply. Your medical health along with any medications being taken CAN affect your dental health. It is critical that we are aware of any medical conditions and/or medications being taken. We thank you for taking the time to complete this form.

Name:_____ Date of Birth:_____

Please specify which of the following conditions you have had, or currently have. Mark those that apply below.

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Behavioral Disorder❖see below
- ☐ Blood Disease/Transfusion
- ☐ Breath Odor
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chemotherapy/Radiation
- ☐ Clenching /Grinding
- ☐ Codeine Allergy
- ☐ Coumadin/Blood Thinners
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever/Seasonal
- ☐ Headaches
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ High blood Pressure
- ☐ HPV
- ☐ Jaundice/Liver Disease
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Limited Opening of Jaw
- ☐ Loose/Sensitive Teeth
- ☐ Mental Disability❖see below
- ☐ Nerve Disorders
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Psychiatric/Psychological
- ☐ Pregnancy—Due: _____
- ☐ Snoring *or* use CPAP (circle)
- ☐ Respiratory Problems
- ☐ Rheumatic fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoker
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Diabetes Type 1 *or* 2 (circle)
- ☐ Tuberculosis
- ☐ Tumors/Ulcers
- ☐ Venereal Disease
- ☐

List medications (including non-prescription) supplements and/or vitamins you are currently taking:

_____

_____

_____

Are you having any pain or discomfort in your mouth presently: Yes_____ No____

_____

* Have you ever had any complications following dental treatment? Yes___ No___
  If yes, please explain:_____
* Is there anything you would like to change about your smile?_____
* Have you been under the care of a physician in the last 3 years? Yes___ No____
  If yes, please explain:_____
* Name of Physician:_____ Phone:_____

Signature:_____ **Date:**_____

❖*If this is checked for a minor or dependent then we require that the parent or guardian remain in the office for this patient's appointment(s).*

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