

1711 NW Grant Ave,
Corvallis, OR 97330
(541) 754-1668
Please email completed form to: office@kentburnettdds.com

420 Smith St
Harrisburg, OR 97446
(541) 995-8234

NAME _____ DATE OF BIRTH _____

Please answer the following questions as completely as possible.

	YES	NO		YES	NO
Are You In Good Health.....	<input type="radio"/>	<input type="radio"/>	Have You Ever Required A Blood Transfusion.....	<input type="radio"/>	<input type="radio"/>
Have There Been Any Changes In Your General Health In The Past Year.....	<input type="radio"/>	<input type="radio"/>	Have You Had Recent Weight Loss.....	<input type="radio"/>	<input type="radio"/>
Date Of Last Physical Exam _____			Have You Ever Taken Fen-Phen/Redux.....	<input type="radio"/>	<input type="radio"/>
Physician's Name _____			Do You Use Tobacco.....	<input type="radio"/>	<input type="radio"/>
Address _____			Do You Or Have You Used Controlled Substances.....	<input type="radio"/>	<input type="radio"/>
Phone Number _____			Are You Wearing Contact Lenses.....	<input type="radio"/>	<input type="radio"/>
Are You Now Under The Care Of A Physician.....	<input type="radio"/>	<input type="radio"/>	Do You Have A Persistent Cough Or Throat Clearing Not Associated With A Known Illness (lasting more than 3 weeks).....	<input type="radio"/>	<input type="radio"/>
Have You Ever Been Hospitalized For Any Surgical Operation Or Serious Illness.....	<input type="radio"/>	<input type="radio"/>	Do You Have Disease, Condition Or Problem Not Listed Above That You Think I Should Know About.....	<input type="radio"/>	<input type="radio"/>
Please Explain _____					
Are You Taking Any Medicine(s) Including Non-Prescription Medicine.....	<input type="radio"/>	<input type="radio"/>	WOMEN ONLY		
If Yes, What Medicine(s) Are You Taking: _____			Are You Pregnant Or Think You May Be.....	<input type="radio"/>	<input type="radio"/>
Have You Had Any Abnormal Bleeding.....	<input type="radio"/>	<input type="radio"/>	Are You Nursing.....	<input type="radio"/>	<input type="radio"/>
Do You Bruise Easily.....	<input type="radio"/>	<input type="radio"/>	Are You Taking Birth Control Pills.....	<input type="radio"/>	<input type="radio"/>

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:			Yes	No	
	YES	NO			
Local Anesthetics Like Novocaine.....	<input type="radio"/>	<input type="radio"/>	Hives Or Skin Rash.....	<input type="radio"/>	<input type="radio"/>
Penicillin Or Other Antibiotics.....	<input type="radio"/>	<input type="radio"/>	Fainting Or Dizzy Spells.....	<input type="radio"/>	<input type="radio"/>
Sulfa Drugs.....	<input type="radio"/>	<input type="radio"/>	Diabetes.....	<input type="radio"/>	<input type="radio"/>
Barbiturates, Sedatives, Sleeping Pills.....	<input type="radio"/>	<input type="radio"/>	Aids Or Hiv Infection.....	<input type="radio"/>	<input type="radio"/>
Aspirin.....	<input type="radio"/>	<input type="radio"/>	Thyroid Problems.....	<input type="radio"/>	<input type="radio"/>
Iodine.....	<input type="radio"/>	<input type="radio"/>	Allergies.....	<input type="radio"/>	<input type="radio"/>
Any metals (nickel, mercury, etc).....	<input type="radio"/>	<input type="radio"/>	Arthritis Or Rheumatism.....	<input type="radio"/>	<input type="radio"/>
Latex / Rubber.....	<input type="radio"/>	<input type="radio"/>	Joint Replacement Or Implant.....	<input type="radio"/>	<input type="radio"/>
Other (LIST) _____	<input type="radio"/>	<input type="radio"/>	Stomach Ulcer.....	<input type="radio"/>	<input type="radio"/>
			Kidney Trouble.....	<input type="radio"/>	<input type="radio"/>
			Tuberculosis.....	<input type="radio"/>	<input type="radio"/>
			Persistent Cough.....	<input type="radio"/>	<input type="radio"/>
			Cough That Produces Blood.....	<input type="radio"/>	<input type="radio"/>
			Chemotherapy (cancer, leukemia).....	<input type="radio"/>	<input type="radio"/>
			Sexually Transmitted Disease.....	<input type="radio"/>	<input type="radio"/>
			Epilepsy Or Seizures.....	<input type="radio"/>	<input type="radio"/>
			Anemia.....	<input type="radio"/>	<input type="radio"/>
			Glaucoma.....	<input type="radio"/>	<input type="radio"/>
			Nervousness.....	<input type="radio"/>	<input type="radio"/>
			Tonsillitis.....	<input type="radio"/>	<input type="radio"/>
			Tumors.....	<input type="radio"/>	<input type="radio"/>
			Mental Health Care.....	<input type="radio"/>	<input type="radio"/>
			Back Problems.....	<input type="radio"/>	<input type="radio"/>
			Chemical Dependency.....	<input type="radio"/>	<input type="radio"/>
			Cold Sores / Fever Blisters.....	<input type="radio"/>	<input type="radio"/>
			Cortisone Treatment.....	<input type="radio"/>	<input type="radio"/>
			Hypoglycemia.....	<input type="radio"/>	<input type="radio"/>
			Eating Disorders.....	<input type="radio"/>	<input type="radio"/>

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

Rheumatic Heart Disease Or Rheumatic Fever.....	<input type="radio"/>	<input type="radio"/>
Scarlet Fever.....	<input type="radio"/>	<input type="radio"/>
Heart Defect Or Heart Murmur.....	<input type="radio"/>	<input type="radio"/>
Heart Trouble, Heart Attack Or Angina.....	<input type="radio"/>	<input type="radio"/>
Chest Pain.....	<input type="radio"/>	<input type="radio"/>
Shortness Of Breath.....	<input type="radio"/>	<input type="radio"/>
Pacemaker.....	<input type="radio"/>	<input type="radio"/>
Heart Surgery.....	<input type="radio"/>	<input type="radio"/>
High/Low Blood Pressure.....	<input type="radio"/>	<input type="radio"/>
Congenital Heart Problem.....	<input type="radio"/>	<input type="radio"/>
Swelling Of Feet, Ankles, Hands.....	<input type="radio"/>	<input type="radio"/>
Hepatitis, Jaundice Or Liver Disease.....	<input type="radio"/>	<input type="radio"/>
Stroke.....	<input type="radio"/>	<input type="radio"/>
Sinus Trouble.....	<input type="radio"/>	<input type="radio"/>
Lung Or Breathing Problems.....	<input type="radio"/>	<input type="radio"/>
Asthma Or Hay Fever.....	<input type="radio"/>	<input type="radio"/>

Reason For Your Visit _____

When Was Your Last Dental Visit _____ What Was Done Then _____

How Often Did You Visit The Dentist Before Then _____

Previous Dentist (Name & Location) _____

Have You Had A Complete Series Of Dental Films (x-rays) Taken (when, Where) _____

How Often Do You Brush Your Teeth _____ How Often Do You Floss Your Teeth _____

Is Your Drinking Water Fluoridated _____

	YES	NO		YES	NO
Do Your Gums Bleed While Brushing Or Flossing.....	<input type="radio"/>	<input type="radio"/>	Do You Bite Your Lips Or Cheeks Frequently.....	<input type="radio"/>	<input type="radio"/>
Are Your Teeth Sensitive To Hot Or Cold Liquids Or Foods.....	<input type="radio"/>	<input type="radio"/>	Have You Noticed Any Loosing Of Your Teeth.....	<input type="radio"/>	<input type="radio"/>
Are Your Teeth Sensitive To Sweet Or Sour Liquids Or Foods.....	<input type="radio"/>	<input type="radio"/>	Does Food Tend To Become Caught Between Your Teeth.....	<input type="radio"/>	<input type="radio"/>
Do You Feel Pain To Any Of Your Teeth.....	<input type="radio"/>	<input type="radio"/>	Have You Ever Had Periodontal Treatment (GUMS).....	<input type="radio"/>	<input type="radio"/>
Do You Have Any Lumps Or Sores In Or Near Your Mouth.....	<input type="radio"/>	<input type="radio"/>	Ever Worn A Bite Plate Or Other Appliance.....	<input type="radio"/>	<input type="radio"/>
Have You Had Any Head, Neck Or Jaw Injuries.....	<input type="radio"/>	<input type="radio"/>	Have You Ever Had Any Difficult Extractions In The Past.....	<input type="radio"/>	<input type="radio"/>
Have You Experienced Any Of The Following Problems In Your Jaw?			Have You Ever Had Any Prolonged Bleeding Following Extractions.....	<input type="radio"/>	<input type="radio"/>
Clicking.....	<input type="radio"/>	<input type="radio"/>	Do You Wear Dentures Or Partials.....	<input type="radio"/>	<input type="radio"/>
Pain (Joint, Ear, Side Of Face).....	<input type="radio"/>	<input type="radio"/>	If Yes, Date Of Placement _____		
Difficulty In Opening Or Closing.....	<input type="radio"/>	<input type="radio"/>	Have You Ever Received Oral Hygiene Instructions Regarding The Care Of Your Teeth And Gums.....	<input type="radio"/>	<input type="radio"/>
Difficulty In Chewing.....	<input type="radio"/>	<input type="radio"/>			
Do You Have Frequent Headaches.....	<input type="radio"/>	<input type="radio"/>			
Do You Clench Or Grind Your Teeth.....	<input type="radio"/>	<input type="radio"/>			

If you could change anything about your smile, what would you change? _____

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 PAYERS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO DR. KENT BURNETT, DDS. INSURANCE BENEFITS OTHERWISE 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 MY DEPENDENTS.

X _____ DATE _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS _____
