PATIENT INFORMATION **William L. Kochenour II, DDS, MS, PA** Date: _______________

Name: ____ ___________ Address: ____________________________________
First Mi Last Nickname

Phone: (H) _________________ (C) _________________ (W) __________________ City ___________________ST _____ Zip__________

Email: ____ Birthdate: ___________ Age: ____ Sex: _____

Would you like to receive appointment confirmation via: Text Message: Yes or No Email: Yes or No

Physician Name: __________________________ Dentist Name: __________________________ Last Visit w/Dentist:______________

DENTAL-MEDICAL HISTORY UPDATE

Heart Disease	Yes	No	Rheumatic/Yellow/Scarlet Fever	Yes	No	Heart Murmur	Yes	No
Respiratory Disease	Yes	No	Acquired Immune Deficiency Syndrome	Yes	No	Mononucleosis	Yes	No
Blood Disease	Yes	No	Rheumatism or Arthritis	Yes	No	Hepatitis	Yes	No
Liver Disease	Yes	No	Fainting or dizziness	Yes	No	Polio	Yes	No
Thyroid Disease	Yes	No	Measles/Mumps/Chicken Pox	Yes	No	Diabetes	Yes	No
Kidney Disease	Yes	No	Drug addiction	Yes	No	Anemia	Yes	No
H.I.V. Positive	Yes	No	Tubes in ears	Yes	No	Hemophilia	Yes	No
Venereal Disease	Yes	No	Stroke	Yes	No	Emphysema	Yes	No
Intestinal Disease	Yes	No	Artificial Joints/Valves	Yes	No	Epilepsy	Yes	No
Bone Disease	Yes	No	Fever blisters	Yes	No	Asthma or Hay Fever	Yes	No
Nervous/Emotional Problems	Yes	No	Facial stitches	Yes	No	Tuberculosis	Yes	No
High or Low Blood Pressure	Yes	No	Is Height & Weight normal for age	Yes	No	Broken bones	Yes	No
Endocrine Problems	Yes	No	Have you had a physical this year	Yes	No	Prolonged bleeding	Yes	No
Problems w/wounds healing	Yes	No	Have you reached puberty	Yes	No	Yellow Jaundice	Yes	No
Tumors or Cancer	Yes	No	Are you in good health	Yes	No	Radiation therapy	Yes	No
Sinus Problems	Yes	No	Do you smoke	Yes	No	Chemical therapy	Yes	No
Headache Problems	Yes	No	Are you under medical care	Yes	No	Blood transfusions	Yes	No
Birth Defects	Yes	No	Are you pregnant	Yes	No	Latex allergy	Yes	No

Are you taking any medications? Yes No Are you allergic to anything? Yes No

List of Medications: ____ What? ____

Are you aware of any other disease, condition, or problem not listed above that we should know about? ________________________________

Have you experienced any injuries to the face, neck or head since you have started your orthodontic treatment? If yes, explain:
____ Do you require Premedication before any dental work? _____________________________

Signature____ Date ______________________________