605.361.9288 | kappenman@midconetwork.com
5704 W 41st St, Sioux Falls, SD 57106 | kappenmanfamilydental.com

KAPPENMAN
FAMILY DENTAL
Developing lasting relationships through quality dentistry

Health Questionnaire

Name ______________________________

Phone ____________________ Birth Date ____________________

Date of last dental visit if new to our clinic? ____________________

Are you satisfied with the appearance of your teeth? ____________________

Do you have any swollen areas or sores in your mouth? ____________________

Do you smoke, vape or use tobacco products? ____________________

Have you ever had any of the following ? Please check those that apply and dates:

- ☐ AIDS
- ☐ Anemia
- ☐ Artificial Joint ____________
- ☐ Blood Disease
- ☐ Cancer ____________
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Attack ____________
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mental Health Disorders
- ☐ Mitro Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker ____________
- ☐ Pregnancy Due ____________
- ☐ Respiratory Problem
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors ____________
- ☐ Ulcers
- ☐ Codeine Allergy
- ☐ Erythromycin Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy

Allergies: ______________________________

Are you taking any of the following: ☐ Pain Medication ☐ Blood Pressure Medications ☐ Blood Thinners ☐ Antibiotics ☐ Calcium Replacement ☐ Steroids

List all current prescriptions, over the counter medications and herbal supplements:

____

Do you have any disease, condition or problem not listed above? If so, explain:

____

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Health Questionnaire, continued

Have you ever had any complications following dental treatment?

____

Primary physician: ____

I understand that all services furnished are charged directly to me and I am responsible for payment. If I carry dental insurance, I understand Kappenman Dental will submit claims and credit any payments to my account. I hereby authorize Kappenman Dental Clinic to administer medications and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page is true and correct to the best of my knowledge. If I have any change in my health, I will inform the doctors at my next appointment.

____ _______________________

SIGNATURE of patient, parent, or guardian Date

Consent/Acknowledgement

By signing this revised form as of 09/23/2013, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign the Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. You may obtain a copy at any time by contacting:

Dawn Jorgensen (605) 361-9288, 5704 W. 41st Street Sioux Falls, SD 57106

I ____ , have had the opportunity to read the consent form. I understand by signing this Consent that I am giving my consent to your use and disclosure of my protected health information for treatment, payment activities health care operations.

SIGNATURE: ____ Date _______________________

REVOKE: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment and healthcare operations.

SIGNATURE: ____ Date _______________________