R. Kyle Avondet, D.D.S.

1525 S. 7 Hwy.
Blue Springs, Mo 64014
Telephone: (816) 224-0088

DENTAL REGISTRATION AND HISTORY

Date Home Phone

Patient Information

Name Soc. Sec. #
Last Name First Name Initial
Address
City State Zip
Sex Age Birthdate Marital Status
Patient Employed by Occupation
Business Address Business Phone
Whom May we thank for referring you?
In case of emergency, notify Phone

Primary Insurance

Person responsible for account
Last Name First Name Initial
Relation to Patient Birthdate Soc. Sec. #
Address (if different than Patient(s) Phone
City State Zip
Employed by Occupation
Business Address Business Phone
Insurance Company
Contract # Group # Subscriber #
Names of other dependents covered under this plan

Additional Insurance

Is patient covered by additional insurance?
Subscriber Name Relation to patient Birthdate
Address (if different than Patient(s) Phone
City State Zip
Subscriber Employed by Business phone
Insurance Company Soc. Sec. #
Contract # Group # Subscriber #
Names of other dependents covered under this plan

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with
Name of Insurance company(ies)

And assign directly to Dr. R. Kyle Avondet, D.D.S., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all Insurance submissions.

Responsible Party Signature Relationship Date

Dental Health History

(Confidential)

Dental History

Reason for today's visit
Former Dentist
Address
Date of last dental care
Date of last dental X-rays
Check if you have had problems with any of the following

Bad breath	Grinding teeth	Sensitivity to hot
Bleeding gums	Loose teeth or broken fillings	Sensitivity to sweets
Clickimg or popping jaw	Periodontal treatment	Sensitivity when biting
Food collection between teeth	Sensitivity to cold	Sores or growths in your mouth

How often do you floss?
How often do you brush?

Medical History

Physician's Name
Date of Last Visit
Have you had any serious illness or operations?
If yes, describe
Have you ever has a blood transfusion?
If yes, give approximate dates
(Women) Are you pregnant? Nursing? Taking birth control pills?

Check if you have or have had any of the following

AIDS	Cortisone Treatments	Hepatitis	Rheumatic Fever
Anemia	Cough, Persistent	High Blood Pressure	Scarlet Fever
Arthritis, Rheumatism	Cough up Blood	HIV Positive	Shortness of Breath
Artificial Heart Valves	Diabetes	Jaw Pain	Skin Rash
Artificial Joints	Epilepsy	Kidney Disease	Stroke
Asthma	Fainting	Liver Disease	Swelling of the Feet or Ankles
Back Problems	Glaucoma	Mitral Valve Prolapse	Thyroid Problems
Blood Disease	Headaches	Nervous Problems	Tobacco Habit
Cancer	Heart Murmur	Pacemaker	Tonsillitis
Chemical Dependency	Heart Problems (describe)	Psychiatric Care	Tuberculosis
Chemotherapy		Radiation Treatment	Ulcer
Circulatory Problems	Hemophilia	Respiratory Disease	Venereal Disease

Medications

List medications you are currently taking

Pharmacy Name
Phone

Allergies

Aspirin	Penicillin
Barbiturates (Sleeping pills)	Sulfa
Codeine	Other
Local Anesthetic	

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold R. Kyle Avondet, D.D.S. or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date
Signature