MONTGOMERY DENTAL CENTER

635 Maysville Rd., Mount Sterling, KY 40353 – 859.498.1215

To speed up the check in process, please fill in ALL information

Do you receive services at any of our other sites? Please check all that apply:

☐ ***Sterling Health Care*** ☐ ***Sterling Women's Care*** ☐***Bath Family Health Services*** ☐***Nicholas Family Health Services***

How were you referred to Montgomery Dental Care? _____

Last Name: _____**First Name**:_____**Middle Name:** _____

Nickname:_____**SSN:**_____**Birth Date:**_____

Gender Identity:
□Male □Female □Transgender Male/Female to Male □Transgender Female/Male to Male □Other □Choose not to disclose

Sexual Orientation: □Straight □Lesbian or Gay □Bisexual □Don't Know □Choose not to disclose

Marital Status: □Divorced □Married □Separated □Single □Unknown □Widow

Race: □American Indian/Alaskan Native □Asian □Black/African American □Native Hawaiian □White □ Other
Ethnicity: □Hispanic/Latino □Non Hispanic/Non Latino

Preferred Language: □English □Spanish □Interpreter Needed

Mailing Address:_____ **Zip Code**:_____

Home Phone: _____ **Cell Phone:** _____**Work Phone:** _____

Email Address: _____**Preferred Communication**: Phone/Email

Preferred Phone Contact: □Home □Cell □Work

Living Arrangements □ Alone □Family □Institution □Relative □Roommates □Spouse Only
Living Situation □ Homeless □Transitional □Doubling Up □Street □Other □Unknown □Not Homeless

Agricultural Worker □ Migrant □Seasonal **Are you a Veteran** □Yes □No

Who is your Primary Care Provider? _____

Pharmacy: _____

In case of Emergency, please contact:

Name_____ **Phone:** _____**Relation:**_____

Address_____

DENTAL INSURANCE INFORMATION:
Primary Insurance: _____ **ID#**_____ **GROUP#**_____
Secondary Insurance: _____ID#_____ GROUP#_____

Subscriber Name:_____**Subscriber Date of Birth**_____

Subscriber Gender:____**Subscriber Phone**_____

Subscriber Address if different from Patient:_____

Subscriber Employer:_____

EMPLOYMENT INFORMATION

□Full-time □Part-time □Unemployed □Full-time Student □Part-time Student
□Retired □Unknown □Active Military Duty

Employer Name: _____ **Employer Phone**:_____

Employer Address: _____

HOUSEHOLD INCOME INFORMATION

What is your annual household income? **How many people are in your household?** _____

☐No income ☐Less than 24,999 ☐25,000 to 39,999 ☐40,000 to 59,999 ☐60,000 to 99,999 ☐100,000 or more

Are you seeking treatment that is related to a Worker Compensation or Auto Accident injury? ☐Yes ☐No

MEDICAL INFORMATION

Please circle any of the following you are being treated for:

Blood Pressure: high or low	Heart Disease	Heart Valve
Rheumatic Fever	Asthma/COPD	Stroke
Hepatitis	Tuberculosis	Seizures
Immunocompromised Disease	Stomach Problems (ulcers, reflux, etc.)	Joint Replacement
Thyroid Problems	Kidney Disease	Back Problems
General Allergies	Pancreatitis	Sinus Problems
Diabetes	Bleeding Problems	Cancer/Radiation
Pacemaker	Headaches	Hemophilia
Other:		

ALLERGIES

FOR FEMALES ONLY

Are you pregnant or could you be? ☐Yes ☐No Date of last menstrual period_____

Are you currently using any type of birth control? ☐Yes ☐No If so, what kind? _____

Please list any medications you are currently taking or have taken in the past for *osteoporosis* (i.e. Boniva, Actonel, Fosamax)

_____

Please list your primary care doctor/provider and contact number:

Provider Name: _____ Phone Number: _____

Do you use tobacco? ☐Yes ☐No

If yes: How much and what type: _____ How long have you used it: _____

Do you use controlled substances (drugs) or have you used in the past? ☐Yes ☐No

Do you receive treatment at a pain clinic, either currently or in the past? ☐Yes ☐No

Please list ALL medications: (including over-the-counter medications)

Medication	Dosage/Strength	Frequency/Doses per day

DENTAL HISTORY

What is the reason for your dental visit today? Exam Pain/swelling Broken tooth/filling

How long has this been a problem or concern? _____

When was your last dental visit? _____

Reason for that visit: _____

Have you ever been shown how to brush and/or floss? ☐Yes ☐No

How many snacks do you eat per day (candy, pop, etc…)?

None 1 – 2 Per Day 3 – 4 Per Day 5 – 6 Per Day More than 4 per day

The above information is accurate and complete, to the best of my knowledge, and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature _____ Date _____

Dentist's Signature _____ Date _____