**Kyle McCracken DDS, MS**
**General, Cosmetic, Implant Dentistry**
**Specialist In Prosthodontics**

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**PERSONAL INFORMATION**

Full Name _____ Today's Date _____
Mr. Mrs. Ms. Rev. Dr.

I prefer to be addressed as _____ Birthdate _____

Whom may we thank for referring you to our practice? _____

Have you or anyone in your immediate family been seen her before? _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

E-mail address _____ Work Phone _____

Preferred contact ❑E-mail ❑Home Phone ❑Cell Phone ❑Work Phone Best time to call _____

Employer _____ Social Security #:_____

Spouse / Partner _____ Day Phone _____

Additional Emergency contact _____ Phone _____

Last dental visit _____ with Dr. _____

**INSURANCE SUBSCRIBER INFORMATION**:

Name:_____ Employer:_____

Date of Birth:_____ Insurance Co:_____

Relationship to Subscriber:_____ Address_____

Insurance ID/SS#_____ Phone #:_____Grp#_____

Why have you made this appointment _____

**Account name preference**: ❑Self ❑Spouse
**Payment preference**: ❑Check ❑Credit card (Visa, MC, Discover)

Physician _____ Phone _____

How would you assess your general health ❑Good ❑Fair ❑Poor Last physical _____

Have you been hospitalized in the last 3 years? ❑Yes ❑No _____

| List Medication: | List Reasons for Medications: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

List Surgeries:

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |

Do you now have or have you ever had the following?

❑YES ❑NO Severe or Frequent Headaches
❑YES ❑NO High Blood Pressure
❑YES ❑NO Heart Attack
❑YES ❑NO Heart Murmur
❑YES ❑NO Angina / Chest Pain
❑YES ❑NO Shortness of Breath
❑YES ❑NO Asthma
❑YES ❑NO Emphysema
❑YES ❑NO Scarlet Fever
❑YES ❑NO Rheumatic Fever
❑YES ❑NO Heart Surgery
❑YES ❑NO Pacemaker
❑YES ❑NO Mitral Valve Prolapse
❑YES ❑NO Congestive Heart Failure
❑YES ❑NO Swelling of the Ankles
❑YES ❑NO Hardening of the Arteries
❑YES ❑NO Abnormal Bleeding
❑YES ❑NO Frequent Nose Bleeds
❑YES ❑NO Blood Transfusion
❑YES ❑NO Fainting
❑YES ❑NO Stroke
❑YES ❑NO Hepatitis
❑YES ❑NO Osteoporosis

❑YES ❑NO Kidney Disease
❑YES ❑NO Cancer
❑YES ❑NO Chemotherapy
❑YES ❑NO Radiation Treatment
❑YES ❑NO HIV / Aids
❑YES ❑NO Shingles
❑YES ❑NO Cold Sores / Fever Blisters
❑YES ❑NO Diabetes
❑YES ❑NO Tuberculosis
❑YES ❑NO Arthritis
❑YES ❑NO Artificial Joint
❑YES ❑NO Artificial Valve
❑YES ❑NO Sinus Trouble
❑YES ❑NO Epilepsy / Seizure
❑YES ❑NO Psychiatric Problems
❑YES ❑NO Depression
❑YES ❑NO Ulcers
❑YES ❑NO Colitis
❑YES ❑NO Anemia
❑YES ❑NO Venereal Disease
❑YES ❑NO Glaucoma
❑YES ❑NO Drug / Alcohol Dependence
❑YES ❑NO Bisphosphonate Therapy

Have you ever had an **ALLERGIC** reaction? ❑No ❑Yes If Yes please list allergies:
Include medications, substances, foods, etc.

_____ _____ _____

Continue on other side if needed

Do you consider yourself under an abnormally high amount of stress? ❑No ❑Yes

Do you sleep well? ❑No ❑Yes

Have you ever smoked? ❑No ❑ I Quit When? _____ ❑Yes - Still do How much? _____

Have you ever chewed tobacco? ❑No ❑ I Quit When? _____ ❑Yes - Still do How much? _____

Do you exercise regularly? ❑No ❑Yes If YES what do you enjoy doing _____

**WOMEN** Are you taking birth control pills? ❑No ❑Yes

Are you pregnant? ❑No ❑Yes - Due date _____

Are you currently nursing? ❑No ❑Yes

The information present on these pages is true to the best of my knowledge. I authorize the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. Upon my verbal agreement following discussion of recommended treatment, I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I have read the above: Signature _____Date _____