KENNETH C. BARNEY, D.D.S.
LVI FELLOW, IAPA FELLOW, AASM, AASDM
EPDS & OKU

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ARTISTRY • INTEGRITY • PASSION

101 NORTH MARY STREET
HEDGESVILLE, WV. 25427

Patient Information & Demographics

Appt date ______________ **Arrival time:** ________ **Appt time:** ________

Name: ______________________ MI: ______ Nickname: ________

Address: ______________________________
City: ______________________ State: ________ Zip: ______
Date of birth: ______________ Age: ______ SSN: ______________
Drivers License ______________________________ State: ______

Marital Status: ☐ Single ☐ Married Spouse name: ______________

Student / School Name: ______________________________

Place of employment ______________________________
Can we contact you at work? ☐ Yes ☐ No Telephone: ______________

Contact Information

Home: ______________ Cell: ______________
Email: ______________________________

Emergency Contact: ______________ Telephone: ______________

Whom may we thank for referring you to our office? ______________

Responsible Party & Family Information

Is any other family member a current patient of Dr Barney's? ☐ Yes ☐ No
If yes who? ______________________________

Please complete if patient is a minor:
Name of responsible party: ______________________________
Relation to patient: ______________ Date of birth: ______________

Insurance Information

☐ On file ☐ NONE

Primary Insurance Name: ______________________________
Subscriber: ______________ Relation: ______________
DOB: ______ ID / SSN: ______________ Group #: ______________
Group Name ______________ Employer ______________
Insurance Phone: ______________ Insurance address: ______________

Secondary Insurance Name: ______________________________
Subscriber: ______________ Relation: ______________
DOB: ______ ID / SSN: ______________ Group #: ______________
Group Name ______________ Employer ______________
Insurance Phone: ______________ Insurance address: ______________

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Established pt update:__________________

Dental History

Reason for today's visit: ____________________

Previous dentist (optional): ____________________ Date of last visit: __________

	Yes	No		Yes	No
Dental problems	☐	☐	Regular dental care	☐	☐
Decay	☐	☐	Gum Disease	☐	☐
Jaw Pain / tiredness	☐	☐	Gums bleed	☐	☐
Floss	☐	☐	Clinch/ Grind teeth	☐	☐
Loose / broken teeth	☐	☐	Bad breath	☐	☐
Smoke / chew tobacco	☐	☐	Lip / cheek biting	☐	☐
Interest in improving smile	☐	☐	Interest in whiter teeth	☐	☐
Periodontal treatment	☐	☐	Orthodontic treatment	☐	☐
Headaches	☐	☐	Facial pain	☐	☐
TMJ pain/noise (clicking, popping)	☐	☐	Tender sensitive teeth	☐	☐
Difficulty Chewing	☐	☐	Limited Opening	☐	☐
Neck pain	☐	☐	Ear Congestion	☐	☐
Postural problems	☐	☐	Dizziness	☐	☐
Ringing in the ears	☐	☐	Insomnia	☐	☐
Tingling/numbness in fingers	☐	☐	Nervousness	☐	☐
Hot / cold sensitivity	☐	☐	Back pain	☐	☐
Difficulty Swallowing	☐	☐	Trigeminal Neuralgia	☐	☐
Bell's palsy	☐	☐	Bad dental experience	☐	☐

Other: ____

Medical History

CIRCLE ALL that apply

AIDS	Cancer	Glaucoma	Liver Disease
Allergies (Seasonal)	Chemotherapy	Heart Condition	Low BP
Anemia	Depression	Heart Murmur	MVP
Angina (chest pain)	Diabetes Type:______	Heart Surgery	Nervousness
Arthritis	Dizziness	Hepatitis Type:____	Pacemaker
Artificial Heart Valve	Drug Addiction	HIV Positive	Rheumatic Fever
Artificial Joints	Emphysema	High Blood Pressure	Seizures
Asthma	Epilepsy	Jaundice	Sinus Problems
Blood Thinner	Excessive Bleeding	Jaw Joint Pain	Sleep Apnea
Bruise Easily	Fainting	Kidney Disease	Stroke

Other: ____ *** **NONE** *** ☐

Are you under a physician's care? ☐ Yes ☐ No Physicians Name: __________________

Are you pregnant or trying? ☐ Yes ☐ No

Do you or have you used synthetic canabinoids *(synthetic marijuana, "spice", "K2", "fake weed")* ☐ Yes ☐ No

Any other information you would like us to know? ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health history, I will inform the doctor at the next appointment

_______________________ Signature

_______________________ Date

Chart: __________

DOB: __________

Patient Name: __________

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Established pt update:___________________

Patient Name: ____________ DOB: ____________ Chart: ____________

Allergies

Please list ALL allergies and include a brief description of the reaction you have to it.

☐ I have no known allergies

	Source of allergy	Reaction
☐	Penicillin	
☐	Codeine	
☐	Sulfa	
☐	Latex	
☐	Metals	
☐	Aspirin	
☐		
☐		
☐		
☐		
☐		
☐		
☐		

Medications

Please list ALL prescription *and* over-the-counter medications.

☐ I am not taking any medications

Medication	Strength	How Often	Date started	Reason for using

_____________________________ _____________________________
Signature Date