



**John R. Gordon, DDS, PC**

5844 NW Barry Road, Suite 220  
Kansas City, MO 64154  
816.505.2222  
Fax: 816.505.1337

NAME \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security No. \_\_\_\_\_

**MAILING ADDRESS**

MARITAL STATUS: \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOWED

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_

PLEASE DESCRIBE THE REASON FOR YOUR CONSULTATION TODAY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE PROVIDE E-MAIL ADDRESS FOR APPOINTMENT CONFIRMATION \_\_\_\_\_

PHONES: Work: \_\_\_\_\_ Home: \_\_\_\_\_ Fax: \_\_\_\_\_  
Cell: \_\_\_\_\_ Pager: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER & ADDRESS: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse's OCCUPATION: \_\_\_\_\_ EMPLOYER & ADDRESS \_\_\_\_\_

**ACCOUNT RESPONSIBILITY (if someone other than yourself)**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Responsible Party's Employer and address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Spouse's Social Security Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

**PLEASE INITIAL BELOW**

\_\_\_\_\_ I hereby authorize Dr. John Gordon to take photographs, x-rays, slides, and/or videos of my face, jaws and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides, and/or videos are used in any publication as or part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of the photographs.

\_\_\_\_\_ I hereby authorize Dr. Gordon to diagnose and treat conditions I present, or provide cosmetic care upon my request, specifically including administration of anesthetics and medications to perform and complete treatment.

\_\_\_\_\_ Agreement is hereby made that my account is my responsibility including all legal fees and expenses associated with the collection of past due accounts. If my account is placed in the hands of an attorney for collection, I agree to pay in addition to the principle balance 20% of the account balance as attorney fees.

\_\_\_\_\_ I understand that 48 hours notice is required for any change in scheduling. If Dr. Gordon's office is not contacted within that time limit, a fee will be charged.

\_\_\_\_\_ I understand that 7 days notice is required for any change in scheduling of COSMETIC CASES. If Dr. Gordon's office is not contacted, in person prior to seven days, a fee will be charged.

\_\_\_\_\_ I understand that I am responsible for any balance not paid by my dental insurance plan.

Please list names of people we can discuss your dental treatment with:

Spouse \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

Parent \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

Other \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

\_\_\_\_\_  
DATE PATIENT RESPONSIBLE PARTY



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Correct answers to the following questions will allow the doctor to treat you on a more individual basis, providing the care appropriate for your particular needs. The medical history is one of the most important pieces of information used by the doctor in diagnosing and treating any of your problems.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Who is the general dentist you normally see? \_\_\_\_\_

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now? .....		
2. Are you under the care of a physician? .....		
If so, what is the condition being treated? .....		
3. Physician's Name: _____ Phone: _____		
4. Have you ever been hospitalized or had a serious illness? .....		
If yes, explain: .....		
5. Have you ever had excessive bleeding following an extraction? .....		
Do cuts take longer to heal now than before? .....		
6. (Women) Are you pregnant? If so, give due date .....		
7. (Women) Do you use birth control pills? .....		
8. Do you use tobacco in any form: If yes, how much? .....		
9. Do you use alcoholic beverages (more than 2 drinks per day)? .....		

10. Do you have or have you had any of the following?

	YES	NO
<b>GENERAL</b>		
Tire easily, weakness .....		
Marked weight change .....		
<b>SKIN</b>		
Eruptions (rash) hives .....		
Change in skin color .....		
<b>EYES</b>		
Visual change .....		
Glaucoma .....		
<b>EARS</b>		
Loss of hearing .....		
<b>NOSE</b>		
Frequent nosebleeds .....		
Sinus problems .....		
<b>THROAT</b>		
Soreness/hoarseness .....		
<b>NERVOUS SYSTEM</b>		
Stroke .....		
Headaches .....		
Convulsions/epilepsy .....		
Dizziness/fainting .....		
Psychiatric treatment .....		
<b>RESPIRATORY</b>		
Tuberculosis .....		
Emphysema .....		
Asthma .....		
Persistent cough .....		
Cough up bloody sputum .....		
Shortness of breath .....		
Difficulty breathing while lying down .....		
<b>ENDOCRINE</b>		
Diabetes .....		
Family history of diabetes .....		
Thyroid condition/goiter .....		
Other .....		

	YES	NO
<b>HEART/BLOOD VESSELS</b>		
Rheumatic fever .....		
Heart murmur .....		
Prolapsed mitral valve .....		
Heart attack/trouble .....		
Swelling of ankles .....		
High blood pressure .....		
Low blood pressure .....		
Congenital heart disease .....		
Artificial heart valve .....		
Pacemaker .....		
Heart surgery .....		
Have taken Fen-Phen .....		
Other .....		
<b>BONE/MUSCLES</b>		
Arthritis/rheumatism .....		
Artificial joints .....		
<b>DIGESTIVE SYSTEM</b>		
Hepatitis .....		
Jaundice .....		
Ulcers .....		
<b>URINARY</b>		
Kidney disease .....		
Increase in frequency of urination (night) ..		
Venereal disease .....		
<b>BLOOD</b>		
Bruise easily .....		
Hemophilia .....		
HIV positive .....		
ARC / AIDS .....		
<b>OTHER</b>		
Radiation therapy .....		
Cancer .....		
Other .....		
Other .....		

I received the Notice of Privacy Practices.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE COMPLETE  
OTHER SIDE**

1. Are you ALLERGIC or have you experienced any reaction to the following?

	YES	NO
Penicillin .....		
Sulfa drugs .....		
Other antibiotics .....		

	YES	NO
Aspirin .....		
Local anesthetics (e.g. novocaine) .....		
Codeine .....		
Other drug allergies .....		

2. Are you taking any of the following types of medications?

	YES	NO
Antibiotics/sulfa drugs .....		
Blood thinners .....		
Blood pressure medication .....		
Thyroid medication .....		
Cortisone/steroids .....		
Tranquilizers .....		

	YES	NO
Insulin/other diabetes drugs .....		
Digitalis/other heart medications .....		
Nitroglycerin .....		
Aspirin .....		
Recreational drugs .....		
Other medications .....		

PLEASE LIST ANY AND ALL MEDICATIONS AND THEIR DOSAGES PER DAY THAT YOU ARE CURRENTLY TAKING:


13. When was your last medical physical? \_\_\_\_\_

14. Please list any surgeries you have had: \_\_\_\_\_

15. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain: \_\_\_\_\_

16. Have you ever had any serious trouble associated with previous dental treatment? \_\_\_\_\_

17. Are you currently experiencing pain in your mouth? \_\_\_\_\_

18. Does dental treatment make you nervous? No \_\_\_\_\_ Slightly \_\_\_\_\_ Moderately \_\_\_\_\_ Extremely \_\_\_\_\_

19. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? \_\_\_\_\_  
If so, when? \_\_\_\_\_

20. What treatments have you had? \_\_\_\_\_

21. Do you have or have you had any of the following?

	YES	NO
Bleeding or sore gums .....		
Unpleasant taste/bad breath .....		
Orthodontic treatment (braces) .....		
Clicking/popping jaw .....		
Difficulty opening or closing jaw .....		
Loose teeth .....		

	YES	NO
Teeth sensitive to hot .....		
Teeth sensitive to cold .....		
Teeth sensitive to sweets .....		
Teeth sensitive to biting .....		
Food impaction .....		
Clenching/grinding .....		
Shifting of teeth .....		

22. How often do you get your teeth cleaned? \_\_\_\_\_

23. When were your teeth last cleaned? \_\_\_\_\_

24. Which of the following do you use at least on a daily basis?

	YES	NO
Manual brush .....		
Electric brush .....		
Dental floss .....		

	YES	NO
Fluoride rinse .....		
Toothpicks .....		
Other: _____		

25. How often do you brush a day? \_\_\_\_\_

26. The brush I use is: Soft \_\_\_\_\_ Medium \_\_\_\_\_ Hard \_\_\_\_\_

I hereby grant permission to the staff of this office for the administration of such medications and anesthetics and the performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. I also grant permission to share information about myself to my referring dentist, other involved parties and my insurance company. The medical and dental information as answered on this form is correct to the best of my knowledge. I will notify this office if there are any changes in my Medical or Dental history.

Signature \_\_\_\_\_

Date \_\_\_\_\_