

KINGRY

Family Dentistry

Patient Information

ABOUT YOU

Date _____
 Name _____ Birthday _____
 Street Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Age _____
 Gender _____ Marital Status _____ Are You a Student? _____ School _____
 Social Security Number _____ Parent (if minor) _____
 Current Employer _____ Work Phone _____
 Employer Address _____
 City _____ State _____ Zip _____

FINANCIAL RESPONSIBILITY

Name _____ Birthday _____
 Street Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____
 Age _____ Relationship to Patient _____
 Social Security Number _____
 Current Employer _____ Work Phone _____
 Employer Address _____
 City _____ State _____ Zip _____

ABOUT YOUR SPOUSE

Name _____ Birthday _____
 Social Security Number _____ Cell Phone _____
 Current Employer _____ Work Phone _____
 Employer Address _____
 City _____ State _____ Zip _____

DENTAL INSURANCE INFORMATION

Employee Name _____ Birthday _____
 Social Security Number _____ Policy Number _____ Group Number _____
 Insurance Company _____ Phone Number _____
 Address _____
 City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____ Phone _____
 Address _____
 City _____ State _____ Zip _____

SECONDARY EMERGENCY CONTACT (required)

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

MEDICAL HISTORY

I. Check any of the following which you have had or now have.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis, Liver Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swelling of Hands or Feet |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Birth Defect | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Heart Problem | <input type="checkbox"/> AIDS or HIV Positive | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Chemotherapy |

II. Please answer each question below by indicating yes or no.

1. Do you now, or have you ever had a problem with alcohol or drugs? Yes No
2. Do you take any blood thinner or high blood pressure medicine? If yes, please list: _____ Yes No
3. Do you take aspirin-type products daily or often? If yes, please list: _____ Yes No
4. Do you take any medication for osteoporosis? If yes, please list: _____ Yes No
5. Are you now taking any other medication? If yes, please list: _____ Yes No
6. Are you now seeing a physician? If yes, name of physician: _____ Yes No
7. Allergies:
 - Are you allergic to latex (rubber)? _____ Yes No
 - Are you allergic to any local anesthetic (like Novocaine)? _____ Yes No
 - Are you allergic to penicillin? If yes, what is the reaction after taking: _____ Yes No
 - Are you allergic to any other medicine? If yes, please list: _____ Yes No
 - Do you have any other allergies? If yes, please list: _____ Yes No
8. Have you been hospitalized within the past 2 years? If yes, when and why? _____ Yes No
9. Do you presently have any disease, illness, or disorder not previously mentioned? Yes No
If yes, please list: _____
10. Women Only: Are you or do you think you may be pregnant? Yes No
Are you taking birth control pills? Yes No

DENTAL HISTORY

1. Are you having any pain or discomfort at this time? Yes No
2. Do you feel nervous about having dental treatment? Yes No
3. Have you ever had a bad experience in the dental office? If yes, what: _____ Yes No
4. Do your gums bleed? If yes, what makes them bleed? _____ Yes No
5. Have you ever had periodontal (gum) treatment? If yes, when: _____ Yes No
6. Do you have any loose teeth? Yes No
7. Do your jaw joints slip, lock, pop or hurt? Yes No
8. Do you have frequent headaches, shoulder aches or neck stiffness? Yes No
9. Do you clench your teeth; or do you grind your teeth at night? Yes No
10. Do you experience dizziness, earaches, or ringing of the ears? Yes No
11. Have you ever been administered nitrous oxide (laughing gas) in the dental office? Yes No
12. Have you ever had radiation treatments to the head, face or neck? Yes No
13. Have you ever had a reaction (fainting, heart racing) to local anesthetic? Yes No
14. Do you have any sores in your mouth? Yes No
15. Do you wear any type of removable mouth appliance (partials or dentures)? Yes No
16. Do you use tobacco in any form (smoke, dip, chew)? If yes, what: _____ Yes No

CONSENT

The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% annum) may be added to my account. I also agree to be responsible for any court costs, attorney fees, and waive any real or personal property exemptions if court action becomes necessary. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____ Witness _____
(Legal guardian if minor)

FINANCIAL AGREEMENT

I understand that all responsibility for payment of dental services in this office for myself or my dependents is mine, due and payable at the time services are rendered. This shall include any deductibles, copays or any services or fees not covered under my insurance contract, if applicable. In the event of non-payment of services, I agree to be responsible for any costs and attorney fees if court action becomes necessary. I further agree that in the event of my default on payment of charges incurred I will bear the cost of a collection fee up to 40% of the principal balance.

Initial _____

CANCELLATIONS AND MISSED APPOINTMENTS

Our office works by appointment only. Our office policy requires at least a 48 hour cancellation notice. Cancellations without a 48 notice or broken appointments will incur an office fee.

Initial _____

MEDICAL RELEASE

I, the undersigned, hereby authorize the doctor or clinical personnel to render treatment. In addition, I authorize the release of any and all office records, medical records and x-rays, without exception, to any doctor or specialty clinic to whom I am referred.

Initial _____

MY INSURANCE

As a courtesy to me, Dr. Kevin Kingry will file my insurance claims on my behalf. At the time of services, I will only be asked to pay my estimated portion of the bill. Dr. Kevin Kingry will not be responsible for my deductibles, maximums, services not covered under my contract, or any errors made by my insurance carrier. Any differences between total charges and my insurance payment are my responsibility. I will be notified of any differences by mail and I understand that payment will be due within 10 days of receipt of such notification. My insurance is an agreement between me and my insurance company. I am responsible for all services rendered to me or my dependents by Dr. Kevin Kingry.

Initial _____

ASSIGNMENT OF BENEFITS

I assign to Dr. Kevin Kingry and this facility any payments received for medical services rendered to the patient indicated. I authorize the use of this signature on all insurance submissions. I hereby authorize the doctor to release to all insurance carriers any and all office records, medical records and x-rays without exception regarding my treatment necessary to secure payment of benefits. I am financially responsible for all charges whether or not they are paid by my insurance.

A photocopy of this authorization is to be considered as the original.

PRINT PATIENT'S NAME

SIGNATURE
PATIENT/PARENT/LEGAL GUARDIAN

DATE