KEVIN F. KINGRY, DMD, P.C.
KINGRY
Family Dentistry

Patient Information

Date ______________________

Name ______________________ Birthday ______________ Age __________
Street Address ______________________
City ______________ State ______________ Zip ______________
Home Phone ______________ Cell Phone ______________
Gender __________ Marital Status __________ Are You a Student? ________ School ______________
Social Security # ______________ Driver's License # ______________
Current Employer ______________ Work Phone ______________
Employer Address ______________________
City ______________ State ______________ Zip ______________

FINANCIAL RESPONSIBILITY

☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Other ______

Name ______________________ Birthday ______________
Street Address ______________________
City ______________ State ______________ Zip ______________
Home Phone ______________ Cell Phone ______________
Social Security # ______________ Driver's License # ______________
Current Employer ______________ Work Phone ______________
Employer Address ______________________
City ______________ State ______________ Zip ______________

PRIMARY DENTAL INSURANCE

☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Other ______

☐ In-Network ☐ Out-Network

Subscriber ______________________ Birthday ______________
SS# ______________ Policy# ______________ Group# ______________
Insurance Company ______________ Insurance Phone Number ______________
Insurance Address ______________________
City ______________ State ______________ Zip ______________

SECONDARY INSURANCE

☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Other ______________

☐ In-Network ☐ Out-Network

Subscriber ______________________ Birthday ______________
SS# ______________ Policy# ______________ Group# ______________
Insurance Company ______________ Insurance Phone Number ______________
Insurance Address ______________________
City ______________ State ______________ Zip ______________

EMERGENCY CONTACT

Name ______________ Phone ______________ Relation ______________

Patient Name ___________________________ ***DOB*** ______________________

MEDICAL HISTORY

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

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

II. Please answer each question below by **circling** 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? 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

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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

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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, 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 48-hour cancellation notice. Cancellations without a 48-hour 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

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SIGNATURE **DATE**
PATIENT/PARENT/LEGAL GUARDIAN