# KINSEY DRIVE FAMILY DENTAL

Date _____

Name _____ Date of Birth _____

Social Security # _____ Driver's License # _____ State _____

Address _____

City _____ State _____ Zip _____

Phone #'s (H) _____ (C) _____ (W) _____

Email _____

Please Circle: Minor Single Married Divorced Widowed Separated

Preferred Pharmacy _____

Pharmacy Address _____

Employer _____ Employer Phone # _____

Spouse/Parent's Name _____ Employer

_____

School/College (if a student) _____

Emergency Contact _____ Phone _____

Whom or what may we thank for referring you? _____

**Insurance Information**

Subscriber Name _____

Relationship to Patient _____ Subscriber Date of Birth _____

Social Security # _____ Member ID _____

Employer _____

Insurance Company Name _____ Group # _____

Insurance Phone #'s for Benefits/Providers _____

# DENTAL HISTORY

Date _____

Full Name _____ Date of Birth _____

How would you rate the current condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____ How long were you a patient? _____

Date of Most Recent: Exam _____ X-Rays _____ Treatment _____

What is your immediate concern? _____

On a scale of 1 (least) to 10 (most), how fearful are you of dental treatment? 1 2 3 4 5 6 7 8 9 10

**Please check yes or no to the following questions**

| Yes | No | |
|---|---|---|
| ____ | ____ | Have you ever had an unfavorable dental experience? |
| ____ | ____ | Have you ever had complications from past dental treatments? |
| ____ | ____ | Have you ever had trouble getting numb, or had any reactions to local anesthetic? |
| ____ | ____ | Did you ever have braces, orthodontic treatment, or had your bite adjusted? |
| ____ | ____ | Have you had any teeth removed? |

Smile Characteristics

| | | |
|---|---|---|
| ____ | ____ | Is there anything about the appearance of your teeth you would like to change? |
| ____ | ____ | Have you ever whitened (bleached) your teeth? |
| ____ | ____ | Have you been disappointed with the appearance of your previous dental work? |

Bite and Jaw

| | | |
|---|---|---|
| ____ | ____ | Do you have problems with your jaw joint, i.e. pain, sounds, limited opening, locking, etc.? |
| ____ | ____ | Have your teeth changed in the last 5 years, become shorter, thinner, or worn? |
| ____ | ____ | Are your teeth crowding or developing space? |
| ____ | ____ | Do you clench your teeth in the daytime or make them sore? |
| ____ | ____ | Do you have any problems with sleep, or wake up with an awareness of your teeth? |
| ____ | ____ | Do you wear, or have you ever worn, a bite appliance? |

Tooth Structure

| | | |
|---|---|---|
| ____ | ____ | Have you had cavities within the last 3 years? |
| ____ | ____ | Do you seem to have too little saliva, or have difficulty swallowing food? |
| ____ | ____ | Do you feel or notice any holes (i.e. pitting, craters) on the biting surfaces of your teeth? |
| ____ | ____ | Are any teeth sensitive to hot, cold, biting, or sweets? |
| ____ | ____ | Do you avoid brushing any part of your mouth? |
| ____ | ____ | Do you have grooves or notches on your teeth near the gumline? |
| ____ | ____ | Have you ever broken teeth, chipped teeth, or had a toothache and cracked filling? |
| ____ | ____ | Do you frequently get food caught between any teeth? |

Gum and Bone

| | | |
|---|---|---|
| ____ | ____ | Do your gums bleed, or are they painful while brushing or flossing? |
| ____ | ____ | Have you ever been treated for gum disease, or been told you have lost bone around your teeth? |
| ____ | ____ | Have you ever noticed an unpleasant taste or odor in your mouth? |
| ____ | ____ | Has anyone in your family had a history of periodontal disease? |
| ____ | ____ | Have you ever experienced gum recession? |
| ____ | ____ | Have you ever had any teeth come loose on their own (without an injury)? |
| ____ | ____ | Have you experienced a burning sensation in your mouth? |

# MEDICAL HISTORY

Date _____

Patient Name _____ Preferred Name _____ Age _____

Name of Physician _____ Most recent physical exam _____

Reason _____

Circle an estimate of your general health: Excellent Good Fair Poor

**Have you ever had an allergic reaction to:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Clindamycin | Yes | No | | Codeine | Yes | No |
| Erythromycin | Yes | No | | Ibuprofen | Yes | No |
| Latex | Yes | No | | Penicillin | Yes | No |
| Sulfa | Yes | No | | Tetracycline | Yes | No |
| Tramadol | Yes | No | | Tylenol | Yes | No |

Other _____

**Please check yes or no to the following questions. Note the date if any answer is yes.**

| No | Yes | Date | |
|---|---|---|---|
| ____ | ____ | _____ | Hospitalization for illness or injury in the last 2 years? |
| ____ | ____ | _____ | Heart problems, or surgery, within the last 6 months? |
| ____ | ____ | _____ | Can you walk up a flight of stairs without having to stop and rest, or getting short of breath? |
| ____ | ____ | _____ | History of uneffective endocarditis? |
| ____ | ____ | _____ | Artificial heart valve or repaired heart defect (PFO)? |
| ____ | ____ | _____ | Pacemaker or implantable defibrillator? |
| ____ | ____ | _____ | Artificial prosthesis (heart valve, joints, hip or knee replacement)? |
| ____ | ____ | _____ | High blood pressure? |
| ____ | ____ | _____ | Low blood pressure? |
| ____ | ____ | _____ | Stroke? |
| ____ | ____ | _____ | COPD? |
| ____ | ____ | _____ | Tuberculosis? |
| ____ | ____ | _____ | Asthma? |
| ____ | ____ | _____ | High cholesterol or taking statin drugs? |
| ____ | ____ | _____ | Diabetes Type 1? |
| ____ | ____ | _____ | Diabetes Type 2? |
| ____ | ____ | _____ | Are you taking anything for Osteoporosis (soft bones, i.e. bisphosphonates)? |
| ____ | ____ | _____ | Is it uncomfortable for you to sit in a dental chair in a laid-back position? |
| ____ | ____ | _____ | Epilepsy or convulsions? |
| ____ | ____ | _____ | Hepatitis Type A, B, C, D, or E (please circle if applicable)? |
| ____ | ____ | _____ | Blood thinners? |
| ____ | ____ | _____ | Kidney disease? |
| ____ | ____ | _____ | Liver disease? |
| ____ | ____ | _____ | Dizziness/history of fainting? |
| ____ | ____ | _____ | HIV/AIDS? |
| ____ | ____ | _____ | Have you undergone chemotherapy or radiation therapy? |
| ____ | ____ | _____ | Smoker, previous smoker, or use smokeless tobacco? |
| ____ | ____ | _____ | Pregnant? |

Do you have any health issues that we need to discuss, or could possibly affect your dental treatment? If yes, please explain.

_____

Please legibly list all medications, supplements, and/or vitamins taken within the last 2 years (or provide a list to the office):

_____

_____

Patient Signature _____ Doctor Signature _____ Date _____

# KINSEY DRIVE FAMILY DENTAL

## Dental Benefits and Explanation

**The patient is responsible for:**

- Understanding their insurance coverage.
- Informing the office of any changes in their insurance coverage.
- Kinsey Drive Family Dental will submit dental claims to your insurance carrier. We also accept benefit assignments, meaning we will **estimate** the expected benefit payment and allow you to pay your **estimated** portion at the time services are provided.
- Kinsey Drive Family Dental requires a $50 deposit to schedule treatment. This deposit allows us to know patients will be coming to appointments as scheduled so we can confidently reserve time for you. The $50 deposit applies to your final fee if you arrive for your appointment. The remaining patient portion is due the day services are rendered.
- Kinsey Drive Family Dental is exuberantly committed to providing accurate estimates of insurance benefits. However, **patients are fully responsible for any balance due after insurance has paid their portion. We take no responsibility for any denials by patient dental plans.**

Any services we provide cannot be billed to Medicaid or DHMO dental insurance plans.

### Payment Options

Payment for the patient's portion is due in full on the date of service. Payment may be made by cash, check, Visa, Mastercard, Discover, American Express, or an outside dental financier.

### Cancellation and Rescheduling Policy

Kinsey Drive Family Dental strives to provide quality dental care in a timely manner. When we schedule an appointment for you, we reserve time for you. Because of this, we require 24 hours notice to cancel or reschedule an appointment. Last-minute cancellations and rescheduling results in open time that we cannot utilize to serve another patient. **If appointments are cancelled or rescheduled in less than 24 hours, a $50 fee will be accessed.** Prepayment may be required if you cancel 2 or more times without a proper 24-hour notice.

**Please read the following authorization and sign for our files**

*I hereby authorize the release of any dental information necessary to process insurance claims or be referred to dental or medical offices. I authorize payment of benefits to the dentist described herein for services rendered. I have also read the above sections and agree to the terms therein.*

| _____ | _____ | _____ |
|---|---|---|
| Name (Printed) | Signature | Date |

# KINSEY DRIVE FAMILY DENTAL

## ***OUR COMMITMENT TO YOU***

**If**, within **5** years, our crowns porcelain veneers, or onlay(s)/inlay(s) break or fracture – and the tooth or teeth are still viable, and you fulfill your commitment (written below) – we will replace any crowns, porcelain veneers, or onlays/inlays with the same type of material at no charge.

## ***YOUR COMMITMENT***

- In order for full-fee replacement to be honored, you need to visit our office for a minimum of 2 times per calendar year for professional cleanings, the evaluation of restorations, and oral cancer screenings. Our fees for prophylaxis cleanings start at $90, exams at $53, and periodontal maintenance at $139. Any required x-rays will be discussed with you.
- If recommended periodontal disease (gum disease) treatments are necessary, 3 to 4 periodontal maintenance cleanings per calendar year will be needed.
- Patients with certain systemic diseases or complications, taking chemotherapy or radiation therapy, or medications causing dry mouth may also invalidate warranty.

Signature _____ Date _____

## Acknowledgement of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication

Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____

This form allows Kinsey Drive Family Dental to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used to carry out treatment, payment, or health care options.

Kinsey Drive Family Dental has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing of this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Kinsey Drive Family Dental.

I understand that at anytime I have the right to revoke this consent provided I do so in writing, but Kinsey Drive Family Dental may still use information to complete any actions it began prior to my revoking consent and which rely on my protected health information. I understand Kinsey Drive Family Dental may refuse service if I revoke this consent.

I understand I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided to me in writing. I understand that while Kinsey Drive Family Dental is not required to agree to my requested restrictions, the practice is bound by that agreement if it does agree.

By my signature below I affirm the above information.

Patient Signature _____ Date _____
Parent Signature (if minor) _____ Date _____
Authorized Representative _____ Date _____

_____ Initials I hereby authorize Kinsey Drive Family Dental to use unsecured email and mobile phone text messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; 2) Information related to billing and payment.

_____ Initials I hereby authorize Kinsey Drive Family Dental may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

_____ Email _____ Home Phone _____ Office Phone _____ Cellphone

_____ Initials I hereby authorize Kinsey Drive Family Dental may disclose my health information to any person(s) who accompany me to my appointment and are present with me in the office while I meet with my dentist and staff.

_____ Initials I hereby authorize Kinsey Drive Family Dental may disclose my personal health information to the person whom I have listed as my emergency contact.

_____ Initials I hereby authorize Kinsey Drive Family Dental may disclose my personal health information to the following person(s):

| Name | Phone Number | Relationship to Patient |
|---|---|---|
| | | |
| | | |
| | | |