KEARBEY
DENTAL GROUP

Patient Information

Patient Name: ____ Date: ____________
Last First MI (Preferred Name)
Gender: ______________ Marital Status: ______________

Social Security #: ______________ Driver's License #: ______________ Birth Date: ______________

Phone (Home): ______________ (Work): ______________ Ext: ________Cell: ______________

Home Address: ______________________ Mailing Address: ______________________
Street Apartment #

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City State Zip Code

Health Information

Date of Last Dental Visit: ______________ Reason for this visit: ______________________

Medical History and Medical Conditions			Have you ever had any of the following?					
AIDS	yes	no	Growths	yes	no	Rheumatic Fever	yes	no
Allergies	yes	no	Hay Fever	yes	no	Rheumatism	yes	no
Alcohol/Drug Abuse	yes	no	Head Injuries	yes	no	Sinus Problems	yes	no
Anemia	yes	no	Heart Disease	yes	no	Stomach Problems	yes	no
Arthritis	yes	no	Heart Attack/Surgery	yes	no	Stroke	yes	no
Artificial Joints/Valves	yes	no	Heart Murmur	yes	no	Tuberculosis	yes	no
Asthma	yes	no	Hepatitis A B C	yes	no	Tumors	yes	no
Blood Disease	yes	no	High Blood Pressure	yes	no	Ulcers	yes	no
Cancer	yes	no	Jaundice	yes	no	Venereal Disease	yes	no
Chemotherapy	yes	no	Kidney Disease	yes	no	**ALLERGIES**		
Diabetes	yes	no	Liver Disease	yes	no	Codeine Allergy	yes	no
Insulin dependent	yes	no	Mental Disorders	yes	no	Penicillin Allergy	yes	no
Diet/Exercise controlled	yes	no	Nervous Disorders	yes	no	Latex Allergy	yes	no
Emphysema	yes	no	Pacemaker	yes	no	Tetracycline Allergy	yes	no
Epilepsy	yes	no	Currently Pregnant	yes	no	Aspirin Allergy	yes	no
Excessive Bleeding	yes	no	Due Date: ____________			Sulfa Allergy	yes	no
Fainting	yes	no	Radiation Treatment	yes	no	Other Allergies:		
Glaucoma	yes	no	Respiratory Problems	yes	no			

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Name of Physician: ______________________ Phone: ______________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- For Women: Are you taking birth control pills? Yes No Are you nursing? Yes No
- Please list any **MEDICATIONS** that you are currently taking and for what condition: ______________________

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Referral Information

How did you hear about our office? ______________________________

Name of person or office referring you to our practice: ______________________

Names of other family members seen in our office? ______________________

Reviewed by Dr.______________________________ Date: ______________

Patient Name (please print): ______________________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________ Birth Date: ______________

Phone (Home): __________ (Work): __________ Ext: _____ Cell: __________

Address: ______________________________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________ Occupation: ______________

Address: ______________________________

Insurance Information

Primary

Name of Subscriber: ______________________________ Is Subscriber a patient? ☐ Yes ☐ No

Last First MI

Subscriber's Birth Date: __________ ID #: __________ Group #: __________

Subscriber's Address: ______________________________

Subscriber's Employer Name: ______________________________

Address: ______________________________

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Insurance Plan Name and Address: ______________________________

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Secondary

Name of Subscriber: ______________________________ Is Subscriber a patient? ☐ Yes ☐ No

Last First MI

Subscriber's Birth Date: __________ ID #: __________ Group #: __________

Subscriber's Address: ______________________________

Subscriber's Employer Name: ______________________________

Address: ______________________________

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Insurance Plan Name and Address: ______________________________

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Consent for Services

Welcome to our office! Thank you for choosing us as your dental care provider. In order to better serve your needs, we feel it is important to understand our financial policy and our standard practices.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Our practice is committed to providing the best treatment for our patients and our charges reflect what is usual and customary for our area.

Please help us to serve you better by: keeping scheduled appointments; providing advanced notice if changes are needed (a 24 hour notice is required); accompany any minor to dental appointments (under age 18 years); and after 2 missed appointments, we reserve the right to dismiss the patient from our practice.

We will be happy to provide you with an estimate for the treatment needed, however, this is simply an estimate and may not always be accurate. In some cases, when work is started, there are unseen repairs and/or conditions discovered, which could not be detected at the time of the original estimate. We must therefore assume no liability to perform services for prices quoted in original estimates and those prices are subject to change.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. We will bill your insurance as a courtesy. We require that you provide the dental insurance information and advisement of subsequent insurance changes or requests. Your insurance policy is a contract between you and your insurance company.

A finance charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

Please note that we are a multiple dentist practice, you may not be called for treatment in the order that you arrive.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

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, I will inform the doctors at the next appointment without fail.

X______________________________ **Date:** __________ **Relationship to Patient:** ______________

Signature of Patient / Guardian / Responsible Party

I have received a DMFS X______________ **I have received and understand the HIPPA sheet X**______________