James S. Kimbrell, D.M.D.

621 Helen Keller Blvd. Suite 100
Tuscaloosa, AL 35404

Date _______________

Please tell us about yourself

Patient's Legal Name:______________________ Nickname:_____________
Date of Birth:_____________ Social Security #:________________________
Home#:(__)_________ Cell#: (__)__________ Email: ____________________
Address: ____
City: _____________________ State: _____ Zip: _________

Marital Status: □ Minor □ Single □ Married □ Divorced □ Widowed

Do you take a pre-medication antibiotic before dental procedures? □ Yes □ No
If yes:
Name of antibiotic: ______________ Name of Pharmacy: _______________

Whom may we thank for referring you? _______________________________

Employer Information

Place of Employment: ________________________Work#: (__)___________
Employer's Address: ____
City: _____________________ State: _____ Zip: _________

Responsible Party Information

Responsible Party Legal Name: ___________________ Date of Birth: _______
Responsible Party's Employer: ____________________ Work#: (__)________
Social Security#: ___________________ Cell#: (__)__________

Insurance Information

Primary Dental Insurance

Insurance Company: ________________________ Phone#: (   )____________

Contract of ID#: ___________________________ Group#: _______________

Policy Holder's Name: _______________________ Date of Birth: __________

Social Security#: ______________ Place of Employment: _________________

Relationship to Patient: ____

Secondary Dental Insurance

Insurance Company: ________________________ Phone#: (   )____________

Contract of ID#: ___________________________ Group#: _______________

Policy Holder's Name: _______________________ Date of Birth: __________

Social Security#: ______________ Place of Employment: _________________

Relationship to Patient: ____

We will be happy to file DENTAL insurance claims for you at no extra charge, if the insurance company will also issue a check payable to the dentist. *In addition, you must provide our office staff proper information (Dental Insurance Card, Social Security Number, and Date of Birth of the person you are filing insurance under).*

The ESTIMATED difference that the insurance does not pay must be paid the day of the office visit.

Office Payment Policy

YOUR PAYMENT OPTIONS AT THE TIME OF SERVICE:
Cash, Personal check, Mastercard, Visa, Discover and Care Credit

LOW MONTHLY PAYMENTS (WITH APPROVED CREDIT):
Care Credit is an independent medical/dental credit card program not affiliated with the office. The Care Credit program offers a low monthly payment plan for those with approved credit. This program is available whether or not you have dental insurance. There is no enrollment fees, annual fees, or down payment required. For your convenience, Care Credit applications are available or you may contact them directly at www.carecredit.com. Approval may be obtained in as little as five minutes.

IF IT BECOMES NECESSARY TO TURN THIS ACCOUNT OVER FOR COLLECTION, I PROMISE TO PAY ALL ATTORNEY'S FEES, COURT COSTS, AND ALL OTHER COSTS OF COLLECTION OF MY ACCOUNT.

* There is a $30.00 service charge on any returned checks

The undersigned agrees to pay for all services rendered. This form was signed in Tuscaloosa County and all services are performed in Tuscaloosa County.

X____Date: ____________________
GUARANTOR- PATIENT OR GUARDIAN IF PATIENT IS A MINOR

Medical History

Name: ______________________________ Date of Birth: _______________

Have you ever had: (check all that apply)

□ Heart problems
(Heart attack, surgery, valve)
□ High blood pressure
□ Chest pains (Angina)
□ Heart murmur
□ Rheumatic fever
□ Anemia
□ Bleeding problems
□ Swelling of hands or feet
□ Artificial joint (hip, knee)
□ Blood transfusion
When?: _____________
□ Tuberculosis (TB)
□ Emphysema
□ Difficulty breathing
□ Asthma
□ Sinus congestion
□ Liver disease
□ Other breathing problems
□ Kidney infections
□ Diabetes
□ Herpes
□ Cold sores or fever blisters
□ Frequent sores or ulcers in mouth
□ Bleeding gums
□ Pain in jaw joint (TMJ)
□ AIDS or been exposed to the
HIV (AIDS) virus
□ Epilepsy
□ Dizzy or fainting spells
□ Seizures
□ Psychiatric treatment
□ Tranquilizing medication
□ Hepatitis
□ Ulcers or stomach problems
□ Thyroid disease
□ Cancer or tumor
□ Surgery or hospitalization in the
past two years? Please list them:
____
____

Are you pregnant? □ Yes □ No
Are you currently under the care of a doctor?
□ Yes □ No
If so, for what reason? __________________
Name of your physician: ________________
Are you currently taking any prescription
Medications? □ Yes □ No
Please list them: _______________________
____
____
____
Do you have any disease or condition not
mentioned? □ Yes □ No
If so, please explain: ___________________
____
Are you **allergic** to any of these?
□ Aspirin
□ Codeine
□ Darvon
□ Penicillin
□ Other antibiotics: ____________________
□ Novocaine
□ Latex
□ Other medications: ___________________
Have you ever had a reaction to an injection
Or medication given to you by your dentist?
□ Yes □ No
Please explain: _________________________

To the best of my knowledge, the above information is accurate. If the patient is a minor,
I, as the parent/guardian give my permission for any needed dental treatment. I understand that is my responsibility to inform the dental office of any changes in my medical status, or that of my dependents.

Signature: _________________________
Date: _____________________________