Kilgore Dental Care

PATIENT INFORMATION

Date _____Patient Name _____Preferred Name _____
Physical Address _____ Home Phone _____
City _____ State _____ Zip Code _____ Work Phone _____
Mailing Address _____ Cell Phone _____
City _____ State _____ Zip Code _____
Sex: M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced (circle one)
Patient SS# _____
Spouse Name _____ Birthdate _____ SS# _____
Spouse Phone# _____ Spouse Address _____
City _____ State _____ Zipcode _____

Email address: _____

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IN CASE OF <u>EMERGENCY</u> PLEASE CONTACT: (Specify someone who does not live in your household)

Name _____ Relationship to you _____
Phone Number of Emergency Contact Person _____
Whom may we thank for referring you? _____

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INSURANCE INFORMATION:

Employer _____
Insurance Company _____ Group # _____

Is patient covered by additional insurance? Yes No Subscriber's Name _____
Subscriber's Birthdate _____ Subscriber's SS# _____ Relationship to Patient _____
Employer _____
Insurance Company _____ Group # _____

Who is responsible for this account (full name)? _____
Relationship to patient _____
Complete only if information has not already been provided above:
Responsible Party SS#_____ Responsible Party Birthdate _____
Responsible Party Address _____ City _____ State _____ Zipcode _____

ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (and/or my dependent(s)) have insurance coverage with _____ and assign payment directly to the doctor for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that my patient responsibility is due at the time of service. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Kilgore Dental Care

MEDICAL/HEALTH HISTORY

Physician's Name _____ **Date of last visit** _____

Please circle Yes or No to indicate if you have had any of the following:

AIDS/HIV	Yes No	Epilepsy	Yes No	Psychiatric Care	Yes No
Anemia	Yes No	Fainting or dizziness	Yes No	Radiation Treatment	Yes No
Arthritis, Rheumatism	Yes No	Glaucoma	Yes No	Respiratory Disease	Yes No
Artificial heart valves	Yes No	Headaches	Yes No	Rheumatic Fever	Yes No
Artificial Joints	Yes No*	Heart Murmur	Yes No	Scarlet Fever	Yes No
Asthma	Yes No	Heart Problems	Yes No	Shortness of Breath	Yes No
Back Problems	Yes No	Hepatitis	Yes No	Sinus Trouble	Yes No
Bleeding abnormally (with extractions or surgery)	Yes No	Hepatitis Type _____		Skin Rash	Yes No
		Herpes	Yes No	Special Diet	Yes No
Blood Disease	Yes No	High Blood Pressure	Yes No	Stroke	Yes No
Cancer	Yes No	BP Meds: _____		Swelling of Feet or Ankles	Yes No
Chemical dependency	Yes No	HIV Positive	Yes No	Swollen Neck Glands	Yes No
Chemotherapy	Yes No	Jaundice	Yes No	Thyroid Problems	Yes No
Circulatory Problems	Yes No	Jaw Pain	Yes No	Tonsillitis	Yes No
Congenital Heart Lesions	Yes No	Joint Replacement	Yes No	Tuberculosis	Yes No
Cortisone Treatments	Yes No	Kidney Disease	Yes No	Tumor or growth on head or neck	Yes No
COPD	Yes No	Liver Disease	Yes No	Mouth Ulcer(s)	Yes No
Cough, persistent or bloody	Yes No	Low Blood Pressure	Yes No	Venereal Disease (STD)	Yes No
Diabetes	Yes No	Mitral Valve Prolapse	Yes No	Weight Loss, unexplained	Yes No
Emphysema	Yes No	Nervous Problems	Yes No	Any hospital stays	Yes No
Wear contact lenses	Yes No	Pacemaker	Yes No	Explain: When _____	
		Women:		_____	
		Are you pregnant?	Yes No	Why _____	
		Due date _____		_____	
		Are you nursing?	Yes No	_____	
		Are you taking birth control pills?	Yes No		

****

MEDICATIONS:
Please list medications you are currently taking or provide a list:

_____
_____
_____
_____
_____

Pharmacy Name _____
Phone# _____

ALLERGIES: (circle)

Aspirin
Barbiturates (sleeping pills)
Opioids (ie. Codeine)
Iodine
Latex
Local Anesthetic (e.g. Novocaine)
Penicillin
Sulfa
Other _____

Have you ever taken a Bisphosphonate? e.g.- Fosamax, Boniva, Actonel, Didronel Yes No*
Are you taking a blood thinner Yes No*

I understand that I may be charged a $15 fee for a missed appointment. I understand that I may be charged a $30 rebilling fee if payment is not arranged after the first billing cycle. If payment is not arranged after the second billing cycle, I understand that my account will be turned over to collections.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____
Guardian/Patient's Signature **Date**
(I have read, agree to, and understand the statement listed above)

Doctor's Signature _____ **Date** _____

Kilgore Dental Care

DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ **City/State** _____
Date of last dental visit _____ **Date of last dental x-rays** _____

Please circle Yes or No to indicate if you have had any of the following:

Bad breath Yes No

Burning sensation on tongue Yes No

Clicking or popping Jaw Yes No

Fingernail biting Yes No

Grinding teeth Yes No

Have you ever experienced loose teeth or broken fillings? Yes No

Mouth pain, brushing Yes No

Periodontal treatment Yes No

Sensitivity to sweets Yes No

Have you experienced problems associated with previous dental work Yes No

Bleeding gums Yes No

Chew on one side of mouth Yes No

Chewing tobacco Yes No

Food collection between teeth Yes No

Gums swollen or tender Yes No

Mouth breathing Yes No

Orthodontic treatment Yes No

Sensitivity to cold Yes No

Sensitivity with biting Yes No

Type of toothbrush: (circle)
Soft Medium Hard

How often do you floss _____

How often do you brush? _____

Blisters on lips or mouth Yes No

Cigarette, pipe or cigar smoking Yes No

Dry mouth Yes No

Foreign Objects Yes No

Jaw pain or discomfort Yes No

Lip or cheek biting Yes No

Pain around ear Yes No

Sensitivity to heat Yes No

Sores, ulcers or growths in your mouth Yes No

Do you like your Smile Yes No
(if no, explain)

_____
_____
_____

Guardian/Patient's Signature _____ _____
Date

Doctor's Signature _____ _____
Date

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete the information below to let us know whose protected health information we can disclose:

Name of patient or individual _____

Other name(s) used _____

Date of Birth _____

I, _____, authorize Kilgore Dental Care to disclose the listed individual's protected
Patient or Guardian
health information. The information disclosure is limited to:

___ <u>All information on record</u> ___ Appointment dates & times ___ Insurance information ___ Employment

___ Medication ___ Account/Billing information

___ Completed and Pending treatment

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Please let us know who we can disclose the individual's protected health information to:

Authorized Person #1:

Name _____ Phone # _____

Relationship to you: _____

Authorized Person #2:

Name _____ Phone # _____

Relationship to you: _____

_____ _____
Guardian/Patient Signature **Date**

_____
Signer's relationship to Patient (e.g. self, parent, legal guardian, power of attorney, etc.)