Kellerman Dental

Date: _____

Patient Information

Last	First	Date of Birth:	Age: Sex: M F
Home Phone ( )	Cell Phone ( )		Work Phone ( )
Address:		City:	State: Zip:
Social Security Number:			
Emergency Contact:		Relationship:	Contact Number: ( )
Email Address:		Occupation:	
How did you hear about our office?		Reason for this Visit:	

If a patient is a minor (under 18), they need to be accompanied to all visits by parent/guardian or a designated adult. Failure to follow this will prevent the minor from being seen for their appointment.

Primary Insurance

Name of Insured:	Date of Birth:	SS or ID#:
Name of Employer:	Union or Local#:	
Insurance Company Name:	Group#	

Secondary Insurance

Name of Insured:	Date of Birth:	SS or ID#:
Name of Employer:	Union or Local#:	
Insurance Company Name:	Group#	

Responsible Party Name (If under 18 Parent or Guardian Name) **Or Circle: Same as Above**

Last:	First:	Relationship to Patient:
Date of Birth:	Home Phone: ( )	Alternate Phone: ( )
Social Security Number:		Employer:

Please circle all services you're interested in:

- Invisalign
- Bridge/ Crowns
- Dental Implants
- Cleanings/ Healthy Gums
- TMJ/ Jaw pain/ Grinding/ Clenching
- Whitening/ Veneers
- Sleep Apnea Treatment

Please list any other concerns/ requests you would like to share:

Patient Medical History

Primary Physician_____ Office Phone_____ Last Exam_____

Preferred Pharmacy: _____ Phone: _____

(Check Each Box)	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain:	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications including bisphosonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Has a physician recommended that you take antibiotics as a pre-medication to your dental treatment?	☐	☐
Please list all current medications:		

(Check Each Box)	YES	NO
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had ay reactions to the following?		
Local Anesthetics (e.g. Lidocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Codeine	☐	☐
Any Metals (e.g. nickel, mercury, etc)	☐	☐
Lactose	☐	☐
Valium	☐	☐
Vicodin	☐	☐
Latex Rubber	☐	☐
Other (please list):	☐	☐
	☐	☐
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:	YES	NO
Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Do you have any of the following:

(Check Each Box)	YES	NO		YES	NO		YES	NO
AIDS or HIV Infection	☐	☐	Fainting/Seizures	☐	☐	Mitral Valve Prolapse	☐	☐
Anemia	☐	☐	Frequently Tired	☐	☐	Pace Maker	☐	☐
Angina	☐	☐	Glaucoma	☐	☐	Psychiatric Treatment	☐	☐
Arthritis	☐	☐	Hay Fever/Allergies	☐	☐	Recent Weight Loss	☐	☐
Asthma	☐	☐	Heart Attack-Date:	☐	☐	Respiratory Problems	☐	☐
Blood Disease	☐	☐	Heart Disease	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Heart Murmur	☐	☐	Sexually Transmitted Disease	☐	☐
Chemo / Radiation Therapy Date of last treatment:	☐	☐	Heart Surgery-Date	☐	☐	Sleep Apnea	☐	☐
			Heart Trouble	☐	☐	Stomach Troubles/ Ulcers	☐	☐
Cardiac Pacemaker	☐	☐	Hepatitis- Circle: A B C	☐	☐	Stroke	☐	☐
Chest Pains	☐	☐	High Blood Pressure	☐	☐	Swollen Ankles	☐	☐
Diabetes	☐	☐	Jaundice	☐	☐	Tuberculosis	☐	☐
Drug Addiction	☐	☐	Joint Replacement- Date:	☐	☐	Thyroid Problem	☐	☐
Easily Winded	☐	☐	Kidney Disease	☐	☐	Other:	☐	☐
Emphysema	☐	☐	Leukemia	☐	☐	Other:	☐	☐
Epilepsy/Convulsions	☐	☐	Liver Disease	☐	☐	Other:	☐	☐
Excessive Bleeding	☐	☐	Low Blood Pressure	☐	☐	Other:	☐	☐
Does the patient have any physical, mental, learning, or developmental disabilities?				☐	☐	If yes, please list:		
Any other special needs that we should be aware of to better help the patient?				☐	☐	If yes, please list:		

Name of Previous Dentist and Location_____

Date of Last Exam_____

(Check Each Box)	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5 Do you have any sores, lumps or abscesses in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

(Check Each Box)	YES	NO
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement:	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐

HIPAA Consent

Authorization to release medical information to other individuals

Date: _____
Patient's Date of Birth: _____
Patient's Name: _____

I hereby authorize Kellerman Dental to release my Protected Health Information either verbally or in printed form to the following persons:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

_____

Patient/ Guardian Signature **Date Signed**

☐ I authorize Kellerman Dental to release the Protected Health Information to anyone that may bring the patient in for their visit whom may not be listed above.

☐ I authorize the release of my personal medical information to any doctor whom I may be referred to.

Acknowledgment of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.
(Patient's Printed Name)

_____

Patient/ Guardian Signature **Date Signed**

Authorization and Release

I hereby grant Kellerman Dental permission to use diagnostic photographs and records in publications and/or on the office website, blog, Facebook and You Tube for informational or marketing reasons. I understand that I have the right to request, in writing, removal of the photo and/or video from the website within 30 working days of receipt of the request by Kellerman Dental. I understand that this photo and/or video may be used in office publications or on a website designed to promote dental services as well as offer information and resources. By signing below, I acknowledge my understanding of the above and grant my permission for use of the photograph(s) and/or video(s). ☐ I choose to not release any photograph(s) or video(s) at this time

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

I understand that providing incorrect information can be dangerous to my health. I authorize my dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Patient/ Guardian Signature **Date Signed**

Kellerman Dental Financial Responsibility Form

Patient's Name: _____ Date of Birth: ____/_____/_____
If patient is under the age of 18, name of individual who is financially responsible for
Patient: _____ Telephone #_____-_____-_____

If you have dental insurance, we will file the claims for you, as a complimentary service. Your complete insurance information must be presented at the time services are provided. If this information changes, it is the patient's responsibility to update Kellerman Dental. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage of payments to Kellerman Dental. We do accept payments from the dental insurance companies; however, we are not contracted with them. It is a contract between you, your employer and the insurance company.

We will provide you with a verbal and written estimate of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates given to us by your insurance company and are not a guarantee that your insurance company will reimburse us/you according to these estimates.

Please note that any difference in payment from your insurance company which could result in an account balance is your responsibility. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. For your convenience, you may keep a credit card on file to process any balance not covered by your insurance or to process any remaining balance not paid within 30 days after insurance payment is received. This card will also be used to reimburse you if there is a credit after insurance has paid. If no card is kept on file, we simply ask for payment in full the day of services.

We accept the following forms of payment:

Cash, Check, Visa, MasterCard and Care Credit

Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee. This fee covers the processing fees that are incurred by our office.

Card Type:_____ Card Number:_____
Exp. Date:_____
Name on Credit Card:_____
Signature:_____

We ask that you realize we do NOT work for an insurance company. Rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we prescribe and the fees we charge WILL ALWAYS BE BASED ON YOUR INDIVIDUAL NEEDS, NOT YOUR INSURANCE COVERAGE.

If a payment has not been received on the account in 90 days, the account will be sent to collections and additional fees will be applied to any unpaid balances.

We request a 24-hour cancellation notice for scheduled appointments. A cancellation fee of $25 will be charged for hygiene and $50 for doctor if a 24-hour notice is not provided.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all the terms and conditions herein.

_____

Patient/ Guardian Signature Date Signed