Welcome to Kelley Family Dentistry

Name: _____
FIRST MI LAST TITLE

Preferred Name: _____ ☐ Male ☐ Female

Address: _____ City _____ State _____ Zip _____

SSN: _____ Birthdate: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____ Occupation: _____

Employer: _____ Work Phone: _____

Employer Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about our office? _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Subscriber # _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Authorization and Release

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 the dentist to release any information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the 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.

I understand I might need Local Anesthetic and do give permission to receive it. All my questions regarding risks of anesthetic have been answered. _____ **Initial**

I consent to the Diagnostic procedures and treatment by the dentist necessary for proper dental care. _____ **Initial**

Monthly Statements: Each month you will receive a statement showing your current balance. After sixty days your account will have incurred a **"Finance Charge" at 1-1/2% interest** added each month. _____ **Initial**

Attorney Fees and Cost: If we are forced to take collection action or any other legal action on your account, you agree to pay all court and collection costs and reasonable attorney's fees. _____ **Initial**

Return Check Policy: You may be charged a service charge of $15.00 for any check not honored as payment on your account. _____ **Initial**

HIPAA: I have had the opportunity to read or have chosen not to read or have had it explained to me. I understand the notice and have had the chance to ask any questions about any matters I don't understand. _____ **Initial**

Signature X _____ **Date** _____

Patient Medical History

Physician _____ Office Phone _____ Date of last Exam _____

1. Are you under medical treatment now? ..... ☐ ☐
2. Have you ever been hospitalized for any surgical operation or serious illness? ..... ☐ ☐
3. Are you taking any medication(s) including non-prescription medicine? ..... ☐ ☐

   If yes, what medication(s) are you taking? _____

   _____

   _____

   _____
4. Do you use tobacco? ..... ☐ ☐
5. Do you use alcohol, cocaine or other drugs? ☐ ☐
6. Are you wearing contact lenses? ..... ☐ ☐
7. Are you allergic to or have you had any reactions to the following

	yes	no
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Jewelry	☐	☐
Latex	☐	☐
Metals	☐	☐
Other	☐	☐

8. Women Only:

	yes	no
a) Are you pregnant or think you might be?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

9. Do you have or have you had any of the following conditions?

	yes	no		yes	no
Abnormal Bleeding	☐	☐	Heart Attack	☐	☐
Alcohol Abuse	☐	☐	Heart Murmur	☐	☐
Allergies	☐	☐	Heart Surgery	☐	☐
Anemia	☐	☐	Hemophilia	☐	☐
Angina Pectoris	☐	☐	Hepatitis A	☐	☐
Arthritis	☐	☐	Hepatitis B	☐	☐
Artificial Heart Valve	☐	☐	Hepatitis C	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐
Blood Transfusion	☐	☐	Joint Replacement	☐	☐
Cancer	☐	☐	Kidney Problems	☐	☐
Cold Sores	☐	☐	Liver Disease	☐	☐
Colitis	☐	☐	Low Blood Pressure	☐	☐
Congenital Heart Defect	☐	☐	Mitral Valve Prolapse	☐	☐
Diabetes	☐	☐	Pace Maker	☐	☐
Difficulty Breathing	☐	☐	Psychiatric Problems	☐	☐
Drug Abuse	☐	☐	Rheumatic Fever	☐	☐
Emphysema	☐	☐	Seizures	☐	☐
Epilepsy	☐	☐	Sexually Transmitted Disease	☐	☐
Facial Surgery	☐	☐	Shingles	☐	☐
Fainting Spells	☐	☐	Sickle Cell Disease	☐	☐
Frequent Headaches	☐	☐	Sinus Problems	☐	☐
Glaucoma	☐	☐	Stroke	☐	☐
HIV+ AIDS	☐	☐	Thyroid Problems	☐	☐
			Tuberculosis	☐	☐
			Ulcers	☐	☐

10. Have you every taken Fosomax, Boniva, Actonel or other Bisphosphonates for the treatment of osteoperosis? ..... ☐ ☐

    Explain _____
11. Have you ever had Chemotherapy or Radiation Therapy? ..... ☐ ☐

    Explain _____

Patient Dental History

	yes	no
1. Do you have any overall concerns with your oral health, ie. teeth, jaw, etc.?	☐	☐
2. Do your gums bleed while brushing or flossing?	☐	☐
3. Are your teeth sensitive to hot/cold, sweet/sour, liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in/near your mouth? .	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Do you have frequent headaches?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you feel excessively sleepy during the day?	☐	☐
10. Do you snore, or have you been told that you snore? ..	☐	☐
11. Have you been told that you gasp for air or suddenly stop breathing while sleeping?	☐	☐
12. Have you ever been diagnnosed with sleep apnea?	☐	☐
13. Have you ever had an overnight sleep study?	☐	☐
14. Do you or have you used a CPAP?	☐	☐
15. Do you wake up in the morning with headaches?	☐	☐
16. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
17. Have you ever had instructions on the care of your gums?	☐	☐

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature X _____ **Date** _____