

Patient Information

Patient Name: _____ Date: _____
Last First MI
 Male Female Married Single Child Other _____
 Social Security #: _____ Birth Date: _____ E-Mail: _____
 Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
 Address: _____
Street Apartment #

City State Zip Code
 Emergency contact _____ Phone # _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis A-B-C | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Joints/Valves | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Surgical Stents |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes-Type 1 or 2 | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pregnancy | |
| <input type="checkbox"/> Glaucoma | Due date: _____ | |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | |

ALLERGIES:

- Codeine
 Penicillin
 Sulfa Drugs
 Latex

Other Allergies:

MEDICATIONS CURRENTLY TAKING:

• If any of the above disorders are checked, please explain in detail: _____

• 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

Date of last visit _____

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

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.

Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
 Name of person or office referring you to our practice: _____ Phone _____

Consent for Services

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.

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. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/4% 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.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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 hereby authorize payment directly to KENNERLY DENTAL GROUP for all insurance benefits otherwise payable to me for services rendered.

I authorize the doctor and/or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

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: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

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

Employer Name: _____ Phone: _____

Address: _____
Street _____ City _____ State _____ Zip Code _____

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ SS #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____ Phone _____

Address: _____
Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ SS #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____ Phone _____

Address: _____
Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Kennerly Dental Group, Inc.

**CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION**

Section A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment, payment activities, and healthcare operations, of the uses and disclosures we may make of you protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kimberly A. Schertzer

Telephone: (314) 842-5177

Fax: (314) 842-9935

Address: 9906 Kennerly Road, St. Louis, Missouri 63128

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____