Updated Health Information

Kennerly Dental Group, Inc.

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

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

☐ AIDS/HIV
☐ Anemia
☐ Arthritis
☐ Artificial Joints/Valves
☐ Asthma
☐ Blood Disease
☐ Cancer- Type ______
☐ Diabetes-Type 1 or 2
☐ Dizziness/Fainting
☐ Epilepsy
☐ Excessive Bleeding
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease

☐ Heart Murmur
☐ Hepatitis A-B-C
☐ High Blood Pressure
☐ HPV- Type ________
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Oral Lesions/Lumps
☐ Pacemaker
☐ Pregnancy
Due date:_________

☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sexual Transmitted Diseases- ________
☐ Sinus Problems
☐ Spinal/Back Issues
☐ Stomach Problems
☐ Stroke
☐ Surgical Stents
☐ Tuberculosis
☐ Tumors/Growths
☐ Ulcers

ALLERGIES:
☐ Codeine
☐ Penicillin
☐ Sulfa Drugs
☐ Latex

Other Allergies:
☐ ________________

MEDICATIONS CURRENTLY TAKING:
____
____
____
____

● If any of the above disorders are checked or not listed, 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 contact information or health, I will inform Kennerly Dental Group at the next appointment without fail.

A service charge of 1½% 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. Should balance on patient account become delinquent and result in the use of a collection agency, patient shall be responsible for agency fees and the added expense shall be placed onto patient account.

An $85.00 per hour fee will be posted to my account for any missed appointments or if I cancel with less than 24 hour notice. I understand that I am responsible for these fees.

______________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

Spouse or Responsible Party Information

(If there has been no change in responsible party check next to "SAME") ☐ **SAME**

Name: ______________________ Relationship to Patient: ______________________
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________
Social Security #: ______________________ Birth Date: ______________________
Phone # (Home): ____________ (Work): ____________ Ext: ______ (Cell): ____________
Email address: ______________________
Address: ______________________
Street City State Zip Code

Employment Information

(If there has been no change in employment status check next to "SAME") ☐ **SAME**

The following is for: ☐ the patient ☐ the person responsible for payment
Employer Name: ______________________ Phone: ______________________
Address: ______________________
Street City State Zip Code

Dental Insurance Information

(Patients are ultimately responsible for understanding their insurance coverage/benefits and informing Kennerly Dental of any changes)

Primary (If there has been no change in primary insurance check next to "SAME") ☐ **SAME**

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: ____________ SS #: ____________ Group #: ____________
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 (If there has been no change in secondary insurance check next to "SAME") ☐ **SAME**

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: ____________ SS #: ____________ Group #: ____________
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: ______________________