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: ____