Kennerly Dental Group, Inc.

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/Concerns: _____

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
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Diseases- _____
- ☐ Sinus Problems
- ☐ Spinal/Back Issues
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Surgical Stents
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Oral Lesions or Lumps of Concern

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 contact information or my health, I will inform Kennerly Dental Group 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/relative ☐ Internet: _____

☐ Dental Office ☐ Yellow Pages ☐ 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, patients understand and agree to make payments for services as rendered, unless financial arrangements are made in advance. The practice depends upon reimbursement from 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. Patients should understand that insurance estimation cannot be guaranteed and they will be responsible for any overages or denial of claims. Patients are ultimately responsible for understanding their insurance coverage and benefits. Patients are responsible for updating any changes in health/medications, insurance coverage, home address, phone numbers, emails, etc.

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.

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, cell 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.

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

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

Spouse or Responsible Party Information

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

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

Primary

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

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:_____