PATIENT INFORMATION

Patient Name: ______________________________ Date of Birth: ____________________
(Last) (M.I.) (First)

Male / Female Married / Single / Divorced / Widowed / Child

Patient Social Security Number: ________________________

Patient Address: ____
(City) (State) (Zip)

HomePhone: ________________ WorkPhone ________________ CellPhone ________________
(Circle the best number for our office to use to contact you)

Referred to our office by: ____

RESPONSIBLE PARTY INFORMATION

Name: ______________________________ Relationship: ____________________

Social Security Number: ________________________ Date of Birth: ____________________

Address: ____

Responsible party phone numbers: Home ____________ Work ____________ Cell ____________

Employer: ______________________________

Dental Insurance

Subscriber Name ____________________ Subscriber ID Number ____________________

Insurance Co. Name ____________________ Group ID Number ____________________

____________________ Insurance Co. Address ____________________

Insurance Co. Phone Number ____________________ ____________________

FINANCIAL POLICY

Payment is due at time of service. As a courtesy, we file your insurance claim for you, but the copayment and deductible must be paid prior to filing. Should insurance deny or delay payment after 90 days, you will be responsible for any balance due. A service charge will be added to accounts after 90 days. Adults bringing minors are responsible for payment and are asked to remain in the office during treatment. We accept personal checks, Visa, Mastercard, Discover and cash.

Patient / Responsible Party Signature: ______________________________ Date: ____________

DENTAL HISTORY

Why have you come to the dentist today? ____________________

Prior dentist name ____________________

Do you have any X-rays that we could request (taken within the last 1 year)? YES _______ NO _______

Have you ever had a problem associated with dental treatment? YES _______ NO _______

Please explain: ____________________

MEDICAL HISTORY

Please circle any medical problems that may apply to you.

- Anemia
- Artificial bones / joints / heart valves / plates
- Asthma / arthritis
- Blood transfusion
- Cancer / chemotherapy
- Congenital heart defect
- Diabetes
- Difficulty breathing
- Drug / alcohol rehab
- Emphysema / glaucoma
- Fever blisters / cold sores
- Heart attack / angina / stroke
- Heart murmur (functional / non functional)
- Hemophilia
- Hepatitis
- High / low blood pressure
- HIV / AIDS
- Kidney problems
- Mitral Valve Prolapse
- Psychiatric problems
- Rheumatic fever / scarlet fever
- Severe / frequent headaches
- Liver problems
- Sinus problems
- Tuberculosis
- Heart surgery / pacemaker

Do you require premedication for heart problems, artificial joints or valves? YES _______ NO _______

Are you taking any medication that acts as a blood thinner? (i.e. Coumadin, Plavix) YES _______ NO _______

Do you have any food, contact or medicine allergies? YES _______ NO _______

Please list allergies: ____________________

Name of your medical doctor / office ____________________ Phone number ____________________

WOMEN: Are you pregnant, nursing or taking oral contraceptives? (Please circle)

Please list any medicines that you are taking: ____________________

____

____

Have you ever been hospitalized? YES _______ NO _______ If so, please give reasons ____________________

____

Your signature gives the doctor and staff permission to treat you, permission to release information to the Insurance company and permission to obtain a credit history when a payment plan is requested.

PATIENT / LEGAL GUARDIAN
SIGNATURE: ____________________ **DATE:** ____________________

Update: Date:	Changes?	YES	NO	Patient Initials
Update: Date: ______	Changes?	YES ______	NO ______	Patient Initials ______
Update: Date: ______	Changes?	YES ______	NO ______	Patient Initials ______
Update: Date: ______	Changes?	YES ______	NO ______	Patient Initials ______
Update: Date: ______	Changes?	YES ______	NO ______	Patient Initials ______
Update: Date: ______	Changes?	YES ______	NO ______	Patient Initials ______
Update: Date: ______	Changes?	YES ______	NO ______	Patient Initials ______
Update: Date: ______	Changes?	YES ______	NO ______	Patient Initials ______

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I ____ have received a copy of this office's Notice of Privacy Practices.

Print Name: ____

Sign: ____

Date: ____________________________

*

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I, __________________________ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

____

{Please Print Name} Relationship

____

{Please Print Name} Relationship

____

{Please Print Name} Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ____

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Karns Family Dentistry

Patient Name: ______________________________ Date:__________________

Cancellation Appointment Policy

Your appointment is a time that has been set aside exclusively for you with Dr Dale Pittenger, or your Hygienist. We understand that your time is very valuable to you, and in an effort to respect your time and that of our other patients, we require a 24 hour notice to change or cancel you appointment. We do understand that we all have busy lives and things can come up at last minute from time to time, however, last minute cancellations and no-show appointments may be subject to a $40 cancellation/no show fee.

Thank you,
Karns Family Dentistry

Signature: ______________________________ Date: _________________