Welcome to Kingston Dental Arts – Tell Us about yourself

Last Name_____First_____MI_____Preferred Name_____

Date of Birth_____/_____/_____Sex (at birth): M F Preferred Pronoun:_____ Social Security #_____

Address_____City_____State_____Zip Code_____

Home # (_____)_____Work # (_____)_____Cell # (_____)_____

Please Circle Preferred Number* E-Mail_____

Occupation _____ Employer:_____

☐ Single ☐ Married/Spouse: _____ ☐ Widowed ☐ Separated ☐ Divorced ☐ Domestic Partner

Emergency Contact_____Relationship_____Phone (_____)_____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Name of person or office_____

☐ Another patient ☐ Another Dental Office ☐ Advertisement ☐ Other_____

DENTAL INSURANCE

Primary Insurance

Subscriber Name: _____DOB: _____ Relationship to Patient_____

Subscriber SSN/ID: _____Subscriber Employer:_____

Insurance Company: _____ Insurance Phone #: (_____)_____

Insurance Company Address _____Group #: _____

Secondary Insurance

Subscriber Name: _____DOB: _____ Relationship to Patient_____

Subscriber SSN/ID: _____Subscriber Employer:_____

Insurance Company: _____ Insurance Phone #: (_____)_____

Insurance Company Address _____Group #: _____

Assignment and Release:
I, the undersigned certify that I (or my dependents) have insurance coverage and assign directly to Kingston Dental Arts all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____/_____/_____

Relationship to Patient_____

Medical Health Questionnaire:
Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient / Legal Guardian _____ Date _____/_____/_____

Signature of Doctor_____

HEALTH HISTORY

Physician's Name_____Physician's Phone (_____)_____Date of Last Visit_____

Please check **Yes** or **No** to indicate if you currently have or previously had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal bleeding w/ Extraction/surgery	☐	☐	Epilepsy	☐	☐	Prosthetic Device
☐	☐	Anemia	☐	☐	Fainting / Dizziness	☐	☐	Psychiatric Care
☐	☐	Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Radiation Treatment
☐	☐	Artificial Heart Valves	☐	☐	Headaches	☐	☐	Recent Surgeries
☐	☐	Artificial Joints	☐	☐	Heart Attack	☐	☐	Sinus Trouble
☐	☐	Asthma	☐	☐	Heart Murmur	☐	☐	Skin Rash
☐	☐	Autoimmune Disease	☐	☐	Heart Surgery	☐	☐	Smoke (cigarette, cigar, pipe)
☐	☐	Back Problems	☐	☐	Hemophilia/ Type_____	☐	☐	Smokeless Tobacco
☐	☐	Blood Disease	☐	☐	Hepatitis/ Type_____	☐	☐	Special Diet
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Chemical Dependecy	☐	☐	HIV Positive/ AIDS	☐	☐	Swelling of Feet or Ankles
☐	☐	Chemotherapy	☐	☐	Jaw Pain	☐	☐	Swollen Neck Glands
☐	☐	Circulatory Problems	☐	☐	Kidney Disease	☐	☐	Thyroid Problems/ Type_____
☐	☐	Cold Sores/ Herpes	☐	☐	Liver Disease	☐	☐	Tonsillitis
☐	☐	Congenital Heart Defect	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis
☐	☐	Cortisone Treatments	☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Disease
☐	☐	Cough, persistent or bloody	☐	☐	Nervous Problems	☐	☐	Weight Loss, unexplained
☐	☐	Diabetes/ Type _____	☐	☐	Neurological Problems	**Women Only:**		
☐	☐	Emphysema or COPD	☐	☐	Osteoporosis	☐	☐	Oral Contraceptives
			☐	☐	Pace Maker	☐	☐	Are you pregnant? Due Date _____/_____/_____
						☐	☐	Are you nursing

Other Conditions not listed:_____

Notes on Medical History:_____

History of Bisphosphonates? (ie. Fosamax/Alendronate, Boniva, Reclast) **Yes** **No** Date last taken? _____

List **ALL MEDICATIONS** you are currently taking:_____

_____

Do you **premedicate** before dental visits? **Y** **N** If so, name of antibiotic taken: _____

ALLERGIES

Y **N** *History of Anaphylaxis?
Y **N** Aspirin **Y** **N** Latex **Y** **N** Penicillin
Y **N** Codeine **Y** **N** Metals **Y** **N** Other Antibiotic:
Y **N** Dental Anesthetics

Other Allergies:

_____ _____

DENTAL HISTORY

Reason for today's visit:_____

Former Dentist _____City_____State_____Date of last visit_____/_____/_____

Please circle check the box to indicate if you have had any of the following:

☐ Bad breath or taste	☐ Dry mouth	☐ Loose teeth	☐ History of periodontal treatment
☐ Bleeding / swollen gums	☐ Food traps between teeth	☐ Mouth breather	☐ Sleep Apnea / Snoring
☐ Blisters or sores in mouth	☐ Grinding/clenching of teeth	☐ History of orthodontics	☐ Sensitive Teeth
☐ Broken teeth or fillings	☐ Jaw pain/ clicking/ popping	☐ Currently in orthodontics	

Patient Name:_____Signature:_____Date:_____

GENERAL INFORMED CONSENT

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. Once the patient is informed of options and cost, I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I also assign all insurance benefits to the Doctor.

Patient Name: **(please print)**_____

Parent or Authorized Representative: (if applicable) _____

Signature:_____Date:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Kingston Dental Arts

*You May Refuse To Sign This Acknowledgment

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

Patient Name (**please print**): _____

Parent or Authorized Representative (if applicable): _____

Signature: _____ Date: _____

*Please identify individuals involved in your care or payment for your care and to whom we may disclose PHI (Protected Health Information) to (**please print**):

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

For Office Use Only

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

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)