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:_____

Kingston Dental Arts – General Informed Consent for Treatment

Patient Name: _____ **Date:**_____

Date of Birth: _____

1. Purpose

I, the undersigned, authorize the dental professionals at **Kingston Dental Arts,** including dental assistants and hygienists, to perform the examination, diagnosis, and any necessary treatment for dental conditions as discussed with me, and which I have reviewed and agreed to proceed with. I understand that I have the right to decline or refuse any recommended treatment. I also acknowledge that the dental provider reserves the right to decline to provide treatment if it is not deemed clinically necessary, if the provider is not comfortable proceeding, or if a professional relationship of trust and communication cannot be maintained. Treatment decisions will be made collaboratively, and the doctor and I will work together to develop a mutually agreed-upon plan of care that prioritizes my oral health and respects professional judgment.

2. Description of Proposed Treatment

Treatment may include but is not limited to:

- Dental examinations
- Dental radiographs (X-rays)
- Cleanings and scaling
- Administration of local anesthesia
- Fillings and other restorative procedures
- Crown or bridge preparations
- Impressions for appliances or prosthetics

3. Medical History and Disclosure

- I understand that it is essential to provide accurate and updated information about my medical history, including any current or past medical conditions, medications (prescription or over-the-counter), herbal supplements, and any use of recreational drugs or substances.
- I acknowledge that failure to disclose this information may increase the risk of complications during or after dental treatment, including but not limited to allergic reactions, adverse drug interactions, delayed healing, or medical emergencies.
- I give Kingston Dental Arts permission to contact my other medical providers, as necessary, to discuss my medical status and/or proposed dental treatment.

4. Local Anesthesia and Potential Risks

I understand that local anesthetics may be used to numb the area for dental treatment. I acknowledge that while generally safe, the use of local anesthesia carries potential risks, which include but are not limited to:

- Allergic reactions
- Prolonged numbness or tingling
- Infection
- Trismus (difficulty opening the mouth)
- Nerve damage (particularly of the inferior alveolar or lingual nerves), which may result in temporary or, in rare cases, permanent numbness, tingling, or pain in lips, chin, tongue, or surrounding tissues

5. Restorative Procedures and Future Treatment Needs

I understand that while restorative work (e.g., fillings, crowns) is intended to repair or protect a tooth, complications may occur. These include, but are not limited to:

- Tooth sensitivity

- Fracture of the tooth
- Pain after treatment
- Deep decay close to the nerve, which may require future treatment such as a root canal, crown or extraction
- Esthetic or functional changes with restorative materials
- Unforeseen allergies or reactions to materials

I understand that while restorative materials are designed to closely mimic the appearance and function of natural tooth structure, they are not identical, and there may be subtle differences in esthetics and function following treatment.

I understand that despite best efforts, a tooth that has been restored today may require further treatment in the future.

I also understand that restorations can alter my bite, which may affect the jaw joint and surrounding muscles, potentially leading to jaw discomfort or temporomandibular joint (TMJ/TMD) symptoms, especially when combined with prolonged mouth opening during treatment.

6. Limited Warranty for Permanent Crown and Bridge Restorations

Our office offers a **5-year limited warranty** on permanent crown and bridge, effective starting the date of initial service by Kingston Dental Arts, when initial restoration was placed and paid for, and covers **fracture or breakage of the crown or bridge restoration** due to normal use, provided all conditions below are met.

To remain eligible for this warranty, the patient must:

- Maintain routine dental **examinations and cleanings at the frequency recommended by the treating dentist** (typically every 6 months, or more frequently as determined by individual clinical needs).
- **Follow all professional recommendations**, including use of a lab-fabricated **occlusal guard** if prescribed
- Maintain **adequate oral hygiene** at home, including brushing and flossing as instructed.

Warranty Exclusions: This warranty does **not** cover:

- **Recurrent decay** (new decay under or around the crown/bridge) resulting from poor oral hygiene or failure to attend recommended maintenance visits.
- Damage resulting from accidents, trauma, neglect, misuse, or habits such as bruxism/clenching if an occlusal guard was recommended but not worn.
- Restorations placed on teeth that were compromised and had a guarded or poor long-term prognosis (these will be disclosed before treatment).

If a crown or bridge restoration fails due to a covered reason and all conditions above have been met, we will repair or replace the restoration at no charge for up to five (5) years from the date of placement.

7. Questions and Understanding

I have had the opportunity to ask questions regarding my treatment and all questions have been answered to my satisfaction. I understand the nature of the treatment and the risks involved.

8. Consent

I voluntarily give my consent for the recommended dental procedures and the administration of any medications or anesthetics necessary for such treatment.

9. Patient Responsibility and Oral Health Maintenance

I acknowledge that the success and longevity of dental treatments are directly influenced by my own actions. I understand that **my diligent home care, personal oral hygiene practices, and regular attendance at recommended dental visits directly affect the outcome of my dental treatments and my overall oral health.**

Patient (or Legal Guardian) 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)