

Patient Information (please print)

Name _____ Social Sec. # _____ Date of Birth _____
 First MI Last

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail _____

Employer _____ Occupation _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Marital Status _____ Spouse's Name _____ Spouse's Work Phone _____

How did you hear about our office? _____

Preferred Appointment Times: **8a - 12p** **1p - 5p** **Mon** **Tue** **Wed** **Thu** **Fri**

Responsible Party (if other than patient)

Person responsible for this account _____ Relationship to Patient _____

Home Phone _____ Social Sec. # _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Work Phone _____

Dental Insurance Information

Policy Holder/Subscriber _____ Relationship to Patient _____

Home Phone _____ Social Sec. # _____ Date of Birth _____

Employer _____ Group # _____ Policy/ID # _____

Insurance Co. Name & Phone # _____

Do you have any additional dental coverage? If so, please complete the following.

Policy Holder/Subscriber _____ Relationship to Patient _____

Home Phone _____ Social Sec. # _____ Date of Birth _____

Employer _____ Group # _____ Policy/ID # _____

Insurance Co. Name & Phone # _____

Consent For Services

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital on any possible complication.
4. I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payment is 30 days late, I understand that the account will incur a 2% finance charge per month. If the account is referred to a collection agency, I understand that I will be responsible for the full account balance, collection costs, accrued interest and attorney's fees (33.3% of the total balance at time of placement).
5. I understand that if I fail to make my scheduled appointments, Kessler & Kessler Dentistry reserves the right to charge me for the lost time.
6. I hereby give Kessler & Kessler Dentistry the absolute right and permission to use my photographs for educational or promotional purposes. The undersigned completely and forever release any rights to present or future compensation in connection with the use of said photographs.

Patient's Signature _____ **Date** _____
(or Parent/Guardian)

Patient's Name _____

MEDICAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Emergency Contact _____ Phone # _____

Emergency Contact (not living with you) _____ Phone # _____

Physician's Name _____ Phone # _____

Last Physical Exam By Your Physician _____

Are you currently taking any medications? Please List:

Any Allergies? (Jewelry/Metals, Latex, Skin, Environmental, Medications)

Do you have any of the following? (Check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Diabetes- Type _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Glaucoma- Type _____ | <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Back/Neck Problems | <input type="checkbox"/> Heart Murmur/MVP | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis- Type _____ | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Canker Sores | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> TMJ/Jaw Pain | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Circulatory Problem | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Respiratory Problems | |

Have you ever had to Premedicate, with an antibiotic, prior to dental treatment? If so, why? _____

<u>WOMEN</u>	Any chance you are pregnant?	Yes	No	Planning on becoming pregnant in the next year?	Yes	No
	Are you nursing?	Yes	No	Are you taking Birth Control Pills?	Yes	No

Are you taking any medications for Osteoporosis or Osteopenia? Yes No Please List _____

Have you every had eye surgery?	YES	NO
Type of surgery _____	Date of surgery _____	
Do you plan on having eye surgery in the next year?	YES	NO
Have you been admitted to a hospital or needed emergency care during the past two years?	YES	NO
If YES, please explain _____		
Do you have any health problems that need further clarification?	YES	NO
If YES, please explain _____		

To the best of my knowledge, all of the above information is true and correct. If ever there are any changes, I will inform Kessler & Kessler Dentistry at the next appointment without fail.

Patient's Signature _____ Date _____
(or Parent/Guardian)