Kinkade Dental Studio

New Patient Information

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

ABOUT YOU

Name: _____ I prefer to be called _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Child ☐ Other **DOB**: __/____/_____ Age: _____ **S.S. #**:_____

Home Address: _____ City_____ State_____ Zip _____

Home Phone: (_____) _____ Work: (_____) _____ ext. _____ Cell: (___) _____

E-mail Address: _____ Facebook User name _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____ City_____ State_____ Zip_____

PERSON RESPONSIBLE FOR ACCOUNT ☐ Same as above

Name: _____ Birth date: ____ /____ /_____ Relation: _____

Billing Address: _____ City_____ State_____ Zip_____

Home Phone: (_____) _____ Work: (_____) _____ S.S. #: _____

Employer: _____ How long there? _____ Occupation: _____

SPOUSE/EMERGENCY CONTACT INFORMATION ☐ Same as above

Name: _____ Relation: _____ DOB: _____/_____/_____

Employer: _____ Work Phone: (____) _____ Home #:_____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone: (_____)_____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth date: ____/____/____ Relation: _____

Insured's Social Security #/ID#: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: (_____)_____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth date: ____/____/____ Relation: _____

Insured's Social Security #/ID#: _____ Insured's Employer: _____

MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: (___) _____

Do you have or have ever had any of the following? Please check those that apply:

- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints*
- ☐ Artificial Heart Valves*
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Fever Blister/Cold Sores
- ☐ Frequent Cough
- ☐ Glaucoma
- ☐ Heart Disorder*
- ☐ Heart Infection*
- ☐ Heart Murmur*
- ☐ Heart Pace Maker*
- ☐ Heart Surgery*
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV*/AIDS
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse*
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Surgical Shunt*
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice
- ☐ Other_____

* This condition may require antibiotic pre-medication for certain dental procedures.

YES NO

☐ ☐ Do you have any health problems that were not listed above or need further clarifications?
If yes, explain:_____

☐ ☐ Are you now under the care of a physician?
If yes, explain: _____

☐ ☐ Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, explain: _____

☐ ☐ Are you taking any medications or herbals?
If yes, list: _____

☐ ☐ Are you allergic to any medications or substances?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Iodine ☐ Metal ☐ Latex ☐ Other _____

☐ ☐ Have you used tobacco? If yes, explain: _____

WOMEN (check): ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X_____ Date_____
Signature of patient, parent, or guardian

X_____ Date_____
Signature of treating Doctor

DENTAL HEALTH QUESTIONNAIRE

*We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan.

*We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern. Once all your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there.

*We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together. Please help us better understand your dental health needs and goals by answering the following questions. (Check the best answer):

1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years?

☐ **Yes** ☐ **No**

2. I have a ☐ **low** ☐ **moderate** ☐ **high** fear of going to the dentist.

3. My mouth and teeth are ☐ **very** ☐ **moderately** ☐ **not comfortable**.

4. I am ☐ **very satisfied** ☐ **satisfied** ☐ **dissatisfied** with the appearance of my teeth.

5. I think my present state of dental health is ☐ **excellent** ☐ **good** ☐ **fair** ☐ **poor**.

6. Do you have discomfort in your jaws (TMJ)? ☐ **YES** ☐ **NO**

7. Have you ever been interested in Braces? _____

8. Are you interested in a whiter smile? ☐ **YES** ☐ **NO**

9. Do you snore? ☐ **YES** ☐ **NO**

10. Have you been diagnosed with Sleep Apnea? ☐ **YES** ☐ **NO**

11. Do your gums bleed? ☐ **YES** ☐ **NO**

12. Have you ever been told you have gum disease? ☐ **YES** ☐ **NO**

13. Are your teeth sensitive to any of the following?
☐ Heat ☐ Cold ☐ Sweet ☐ Pressure

14. I would say that my main concerns with my dental health are:

_____

15. Previous Dentist: _____
Date of last visit: _____

Reason for leaving: _____

Qualities you like in a Dentist? _____

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **48-hours (two business days) advanced notification** so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

A nonrefundable deposit is required for any appointment over 1 hour and 30 minutes. The deposit amount shall be 50% of the estimated patient copayment for that particular visit. Any cancellation less than 48 hours in advance will deem the deposit non refundable.

I understand that Kinkade Dental Studio requires 48 hours (two business days) notice to cancel or reschedule an appointment. I agree that failure to providesuch notice will result in up to a $100/hr cancellation fee and a $250 non -refundable deposit requirement on any future scheduled appointments.

FINANCIAL POLICY

Unless another financial option is PRE-ARRANGED, **payment in full is due the day of treatment**. If we are submitting claims to insurance the estimated portion will be the amount due. For patients that have insurance plans that pay the insured the full amount will be due at time of service.

Payment Options

1. For your convenience we accept Cash, Check, Visa, MasterCard, Amex & Discover.
2. We also offer short and long-term financing options. (Interest-free options may apply)

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you during the Financial Arrangements.

Finance Charge and Fees

- Balances in excess of 60 days are subject to a finance charge of 1.75% per month (21% annual).
- Returned checks are subject to a $30 accounting fee.

AUTHORIZATION AND CONSENT

General Consent to Treatment
I agree and consent to a dental examination by the Doctor. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information
I authorize my Doctor to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits
I authorize and request my insurance company to pay my benefits directly to my Doctor.

Photography Release
I authorize the Doctor to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options.

I understand and will comply with office **Appointment Policy**.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.
I authorize **Photographs** to be taken of me and shown to other patients.

X _____ Date _____
Signature of patient, parent or guardian

NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that I may ask any questions I might have regarding this notice.

Signature _____ Date _____

SUBMIT