WELCOME

Help us get to know you...
(this information is strictly confidential)

DATE ________________

NAME ____ SOC. SEC. NO. ______________________________
LAST NAME FIRST NAME MIDDLE INITIAL

BIRTHDATE ________________ AGE ______ EMAIL ___________________________ CELL _________________________________

HOME ADDRESS ____ HOME PHONE ___________________________
STREET

____ WORK PHONE ____________________________
CITY STATE ZIP

EMPLOYER _________________________________ OCCUPATION ____________________________________

MARITAL STATUS (CIRCLE) S - M - W - D (CIRCLE) MALE FEMALE REFERRED BY __________________________________

SPOUSE'S NAME ________________________________ SPOUSE'S DOB ______________ SPOUSE'S SSN ______________________

SPOUSE'S EMPLOYER ____

EMERGENCY CONTACT ___________________________ PHONE ______________________ RELATIONSHIP___________________

DENTIST LAST VISITED ____ DATE OF VISIT ________________________

REASON FOR DENTAL VISIT ____

IS THERE ANYTHING YOU WOULD CHANGE ABOUT YOUR SMILE? ____

____

HAVE YOU BEEN TREATED FOR (CIRCLE):

1 HEART DISEASE/TROUBLE
2 RHEUMATIC FEVER
3 HEART MURMUR
4 HIGH OR LOW BLOOD PRESSURE
5 CONGENITAL HEART LESIONS
6 ANEMIA
7 STROKE
8 PROLONGED BLEEDING
9 TUBERCULOSIS
10 ASTHMA
11 EMPHYSEMA
12 HAY FEVER
13 SINUS TROUBLE
14 ANTIBODY POSITIVE FOR HIV
15 ULCERS
16 HEPATITIS/ JAUNDICE
17 CIRRHOSIS
18 LIVER DISEASE
19 KIDNEY DISEASE
20 SEXUALLY TRANSMITTED DISEASE
21 DIABETES
22 THYROID DISEASE
23 EPILEPSY
24 CANCER
25 ARTHRITIS
26 GLAUCOMA
27 CURRENTLY PREGNANT
28 AIDS
29 ORGAN TRANSPLANT
30 ARTIFICIAL JOINT
Date: ________
31 NONE OF THE ABOVE

OTHER MEDICAL PROBLEMS ____

ALLERGIES (CIRCLE): Penicillin Local Anesthetics
Latex Codeine Other (List) ____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: ____

____

PHYSICIAN: ________________________________ **PHYSICIAN PHONE:** ____

____

(continued on the back)

OFFICE USE ONLY

DATE: _________________________
HEALTH CHANGES: MEDICATIONS:
____ ____

DATE: _________________________
HEALTH CHANGES: MEDICATIONS:
____ ____

DATE: _________________________
HEALTH CHANGES: MEDICATIONS:
____ ____

DATE: _________________________
HEALTH CHANGES: MEDICATIONS:
____ ____

AGREEMENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I have received the Notice of Privacy Practice written in plain language. The Notice provides in detail the uses and the disclosures of my protected health information that may be needed by this practice, my individual rights and the practice legal duties with respect to my protected health information. I give my permission to Drs. Kaiser and Hoehner and staff to take clinical records and/or photographs of my dental treatment for educational and instructional purposes. I authorize payment of insurance benefits to Drs. Kaiser & Hoehner

______________________________ ______________________

Signature Date

ADDITIONAL DISCLOSURE AUTHORITY

May we discuss your treatment with:

☐ Yes ☐ No Entire Immediate Family
☐ Yes ☐ No Spouse Only
☐ Yes ☐ No Other ______________________

FINANCIAL POLICY

Full payment for services is due the day they are rendered. We will gladly submit your dental insurance claims and ask that you pay your estimated portion at the time of your visit. All balances not paid within thirty days of treatment are subject to interest at a rate of 1.5% per month. Annual percentage rate is 18%.
****Filing insurance claims is a service we provide without charge and in no way relieves you of responsibility of your bill.**

Dental Insurance Company ______________________Group # ________Phone #______________

Policy Holder ______________________ ID/SS# ______________________ D.O.B. ____________

Do you have secondary insurance coverage? ☐ Yes ☐ No

If Yes: Insurance Name____________________Policy Holder ________________________

ID/SS#____________________D.O.B.____________Group #_____________Phone #______________

There will be a $50 charge for all broken appointments or appointments not cancelled 48 hours in advance.

This office will attempt to complete your treatment as promptly as possible. Please arrive ten minutes prior to your appointed time.

Signature ______________________________ Today's Date ______________________