

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 CITY STATE ZIP

WORK ADDRESS _____ WORK PHONE _____
STREET CITY STATE ZIP

EMPLOYER _____ OCCUPATION _____

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

SPOUSE'S NAME _____ SPOUSE'S RES. ADDRESS _____

SPOUSE'S EMPLOYER _____ SPOUSE'S BUS. ADDRESS _____

PARENT OR NEAREST LIVING RELATIVE: RELATIONSHIP _____

RELATIVE'S NAME _____ RELATIVE'S ADDRESS _____

RELATIVE'S PHONE _____ RELATIVE'S EMPLOYER _____

PHYSICIAN _____ PHYSICIAN'S ADDRESS _____

DENTIST LAST VISITED _____ DATE OF VISIT _____

HAVE YOU BEEN TREATED FOR (CIRCLE):

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

OTHER MEDICAL PROBLEMS _____

ALLERGIES (CIRCLE): Penicillin Local Anesthetics
Codeine Other (List) _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

REASON FOR THIS DENTAL VISIT _____

IS THERE ANYTHING YOU WOULD CHANGE ABOUT YOUR SMILE? _____

(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 this practice's 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 and Hoehner.

Signature

Date

ADDITIONAL DISCLOSURE AUTHORITY

<i>May we discuss your treatment with:</i>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Entire Immediate Family
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Spouse Only
<input type="checkbox"/> Yes	<input type="checkbox"/> 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.**

Please Check: Cash/Check MasterCard or Visa

Dental Insurance Company Name _____ Group # _____ Phone # _____

Subscriber Name _____ ID/SS# _____ D.O.B. _____

Do you have secondary insurance coverage? Yes No

If Yes: Insurance Name _____ Subscriber Name _____

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 _____