Patient Name ______________________ Date: ______________

Gender: M F Birth Date (mm/dd/yyyy): ______________ Married Single Child Other

Email Address: ______________________ Home Phone: ______________

Day Time Phone: ______________ Preferred Method of Contact: ______________ SSN: _____-_____-______

Address: ______________________ Apt#: ________

City: ______________ State: ________ Zip Code: ________

Employer: ______________________ Occupation: ______________

Emergency Contact: ______________ Phone: ______________ Relationship: ______________

Responsible Party Information (if other than patient)

Name: ______________________ Relationship: ______________

Gender: M F Birth Date: ______________

Email: ______________________ Home Phone: ______________

Day Time Phone: ______________ Preferred Method of Contact: ______________

Address: ______________________ Apt#: ________

City: ______________ State: ________ Zip Code: ________

Employer: ______________________ Phone: ______________

Insurance Information

Primary

Name of Insured: ______________________ (Last, First, MI) is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: ______________ ID #: ______________ Group #:______________

Insured's Address: ______________________ (Street, City, State, Zip Code)

Insured's Employer Name: ______________________

Address: ______________________ (Street, City, State, Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ______________________

Secondary

Name of Insured: ______________________ (Last, First, MI) Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: ______________ ID #: ______________ Group #:______________

Insured's Address: ______________________ (Street, City, State, Zip Code)

Insured's Employer Name: ______________________

Address: ______________________ (Street, City, State, Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ______________________

Referral information

Whom may we thank for referring you to our practice? ______________________________

We consider the referral of patients to our office the highest form of compliment, please tell the person referring you to our office thank you!

Important Dental Information

Name of General Dentist: ______________________________ City: ______________________

Phone Number: ______________________________

Date of Last Cleaning: ______________________ Are you apprehensive about dental work? ☐ Yes ☐ No

Have you had previous treatment? ☐ Yes ☐ No What have you been treated for? ______________________

____

Are you having any dental pain or discomfort? ☐ Yes ☐ No

If Yes, please tell us about it: ______________________________

____

Have you ever gone to your physician to pre-medicate with antibiotics prior to dental treatment? ☐ Yes ☐ No

If Yes, which medication(s) were you given? ______________________________

____

Why was this prescribed for you? ______________________________

____

Check all that apply

___ Bad Breath	___ Bleeding Gums	___ Difficulty Chewing	___ Painful Gums	___ Sensitive Teeth	___ Grinding
___ Bad Taste	___ Clenching	___ Headaches	___ Receding Gums	___ TMJ	___ Dry Mouth

Preferred Pharmacy

Name of Preferred Pharmacy: ______________________________

Preferred Pharmacy Location: ______________________________

Preferred Pharmacy Phone Number: ______________________________

Health Information

Name of Primary Care Physician: ______________________ Phone: ______________

Date of last physical exam: ____________ Results: ______________________

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If Yes, please explain: ______________________

Please list any medications, including non-prescription drugs, taken on a regular basis:

____

Have you had surgery or x-ray treatment for a tumor, growth or other conditions of your head, mouth or lips? ☐ Yes ☐ No

Are you currently or have you taken: Actonel ___ Aridia ___ Boniva ___ Fosamax ___ Zometa ___

Have you ever had bleeding or difficulty with blood clotting? ☐ Yes ☐ No

Are you taking blood thinners? (Coumadin, etc.) ☐ Yes ☐ No If Yes, last INR Level: ________ day ________

Do you take Aspirin regularly? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If Yes, for how long: ________ Packs per day: ________

Do you drink alcohol? ☐ Yes ☐ No If Yes, drinks per month: ________ Week: ________ Day: ________

Do you use recreational drugs? ☐ Yes ☐ No If Yes, for how long: ________ Which drug(s): ________

Are you taking female hormones (oral contraceptives, HRT, etc.)? ☐ Yes ☐ No Which one? ______________

Are you pregnant? ☐ Yes ☐ No

Have you reached menopause? ☐ Yes ☐ No

Are you breast feeding at the present time? ☐ Yes ☐ No

Have you ever had any of the following? Please check those that apply.

___ AIDS	___ Dizziness	___ Jaundice	___ Rheumatism
___ Allergies	___ Epilepsy	___ Kidney Disease	___ Seizures/Convulsions
___ Anemia	___ Excessive Bleeding	___ Liver Disease	___ Sinus Problems
___ Arthritis	___ Fainting	___ Mental Disorders	___ Sleep Apnea
___ Artificial Joints	___ Glaucoma	___ Nervous Disorders	___ Stomach Problems
___ Asthma	___ HIV	___ Organ Transplant	___ Stroke
___ Bacterial Endocarditis	___ Head Injuries	___ Pacemaker	___ Thyroid Disease
___ Cancer	___ Heart Disease	___ Prostate Disorder	___ Tuberculosis
___ Diabetes	___ Heart Murmur	___ Prosthetic Implant	___ Tumors
Type: ___	___ Hepatitis Type: ___	___ Radiation Treatment	___ Ulcers
Last A1C Level: ___	___ Herpes	___ Respiratory Problems	___ Venereal Disease
	___ High Blood Pressure	___ Rheumatic Fever	___ Other: ___

Have you ever had an adverse reaction or allergy to any of the following:

___ Aspirin	___ Codeine Allergy	___ Penicillin Allergy	___ Valium/Tranquilizers
___ Anti-inflammatory Medications	___ Dental Anesthetics	___ Percodan Allergy	___ Other: ___

Type of reaction: ___

Are there medications you cannot take: ___

To the best of my knowledge, the information provided is true and correct.

Signature of Patient or Guardian:	Date:

Financial Policy

It is our mission to provide you with the best care dentistry has to offer. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to many satisfied patients. Below are some important things you should know:

Please read and initial each item below:

Your initial consultation exam with the doctor will be billed to your insurance. If your insurance company does not cover the cost of the appointment, you are responsible for the balance owing and you will be billed for the balance.

For Dental Implant Treatment: The restorative portion of your implant treatment will be an additional cost and the treatment will be completed at and billed through your general dentist's office.

_____ We **require payment for your anticipated cost of treatment (less expected insurance coverage) in full for your procedure on the day of your surgery.** We accept Visa, MasterCard, American Express, cash, and checks. If you are interested in a financing option, we offer third party financing, with an interest free revolving charge designed to meet your treatment plan needs on approved credit.

_____ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require **at least 48-hour** notice to avoid a **$50/hour cancellation fee** (emergencies are an exception).

_____ In the event of an emergency after regular business hours a **$95 emergency fee** will be charged for established patients, in addition to the necessary treatment fees.

_____ Your dental plan is based upon a legal contract made between your employer and an insurance company. **If you have any questions regarding the limitations of your dental plan, please contact your employer or insurance company directly. Dental insurance plans were established to assist the insured with payment of examinations, some x-rays, and some preventative care. It was not intended to cover all of your dental care costs.**

_____ We currently can submit claims to all private dental care insurance plans. This means that we work with literally hundreds of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

I have read the above conditions and understand that I am responsible for all costs for treatment performed at Kirkland Periodontics & Implants on the day of treatment. If I have chosen to have Kirkland Periodontics & Implants submit a claim to my insurance carrier for my treatment, I understand that Kirkland Periodontics & Implants will reimburse me for the amount paid by my insurance carrier.

Print Name: ____ Date: ____________________

Patient/Parent/Guardian Signature: ____