KERRY FAMILY DENTAL

3250 Plymouth Rd, Suite 104
Ann Arbor, MI 48105
info@kerryfamilydental.com
734-995-0515

Patient Full Name _____ Primary Phone# _____ Cell ☐ Work ☐ Home ☐

Address _____ City _____ State _____ Zip _____

Social Security # _____ Birthdate _____ Email _____

GENERAL INSURANCE INFORMATION

Name of Primary Dental Insurance Company _____ Group # _____

Policyholder's Name _____ ID or SS# _____ Birthdate _____

Policyholder's Employer _____ Years with firm _____

Your relationship to policyholder _____ Have you used this dental insurance Select one ☐ Yes ☐ No

Name of Secondary Dental Insurance Company _____ Group # _____

Policyholder's Name _____ ID or SS# _____ Birthdate _____

Policyholder's Employer _____ Years with firm _____

Your relationship to policyholder _____ Have you used this dental insurance Select one ☐ Yes ☐ No

Primary Care Physician _____ Office Phone # _____

Person financially responsible _____ Relationship to you _____

Billing address: Street _____ City _____ State _____ Zip _____

Whom should we notify in case of an emergency: Name _____ Phone _____

How did you hear about our office? _____

MEDICAL & DENTAL INFORMATION

(Answers to the following questions are for our records and will be considered confidential)

Reason for today's visit

Are you in pain?
☐ Yes
☐ No

For how long?

Please check any of the following items related to your dental health: ☐ N/A

- ☐ Discomfort, clicking, or popping in jaw
- ☐ Stained teeth
- ☐ Red, swollen, or bleeding gums
- ☐ Locking jaw
- ☐ A removable dental appliance
- ☐ Bad breath/odors from mouth
- ☐ Blisters/sores in or around the mouth
- ☐ Burning tongue/lips
- ☐ Prolonged bleeding from an injury/extraction
- ☐ Toothache/throbbing
- ☐ Teeth grinding/clenching
- ☐ Recent infections or sore throat
- ☐ Lost/broken filling(s)
- ☐ Difficulty closing/opening jaw
- ☐ Loose/shifting teeth
- ☐ Broken/chipped tooth
- ☐ Food catching between teeth
- ☐ Gum/periodontal disease
- ☐ Swelling/lumps in mouth
- ☐ Root canal

Are any of your teeth sensitive to:
☐ Cold ☐ Hot ☐ Sweets ☐ Biting

Last dental exam/cleaning

Last dental x-rays

Times a day you brush?

Times a week you floss?

How would you rate your smile? (1-10)

Would you like whiter teeth?
☐ Yes
☐ No

Turn over for more →

Select one

Yes No

___ ___ **1.** Do you consider your general health to be good? Approximate date of last physical examination?

___ ___ **2.** Are you being treated for any condition by a physician now? For what?

___ ___ **3.** Are you now taking any medications (drugs or pills)? *Please bring a list of all your medications from your health care provider to your initial appointment.*

___ ___ **4.** Are you allergic or have you reacted adversely to any of the following?

___ Local anesthetic (novocaine)
___ Penicillin or any other antibiotics
___ Aspirin
___ Barbiturates (sleeping pills)
___ Codeine
___ Iodine
___ Nonsteroidal anti-inflammatory (Advil/Ibuprofen)
___ Other

___ ___ **5.** Have you ever had a serious illness or operation?

___ ___ **6.** Do you smoke, vape or use smokeless tobacco? Which? How often and how long?

___ ___ **7.** Do you typically breathe through your mouth?

___ ___ **8.** Have you had any teeth removed?

WOMEN ONLY:

___ ___ Are you pregnant?

9. Please check any of the following that you have experienced.

___ Injury to face or jaws
___ High blood pressure ___ Low blood pressure
___ Blood transfusion
___ Bleeding problems
___ HIV exposure (AIDS)
___ Prosthetic joint replacement
___ Any organ transplants
___ Rheumatic fever
___ Heart murmur
___ Heart attack or disease
___ Angina
___ Mitral valve prolapse
___ Stroke
___ Congenital heart lesions
___ Bacterial endocarditis
___ Diabetes (sugar disease)
___ Kidney or bladder trouble
___ Hepatitis or liver trouble
If yes, check the following
___ Hepatitis A infectious
___ Hepatitis B serum
___ Hepatitis C
___ Jaundice
___ Tuberculosis
___ Venereal disease
___ Lung trouble
___ Irradiation or chemotherapy
___ Asthma
___ Hay fever
___ Blood disorder
___ Psychiatric treatment
___ Frequent severe headaches
___ Cortisone, hydrocortisone, or prednisone
___ Frequent canker or cold sores
___ Tendency to bruise easily
___ Tendency to faint
___ Persistent cough
___ Glaucoma
___ Cold Sores

10. Is there any health information which wasn't asked, which you feel may influence your dental treatment?

I certify that I have read and understand the above. I will not hold my dentist, or any other member of his or her staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient's Signature _____ Date _____

CONSENT & RESPONSIBILITY

I hereby authorize and request the performance of dental services for myself _____ or for: _____

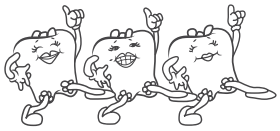
I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his or her supervised staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am ultimately financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

I hereby authorize Kerry Family Dental to release information about my diagnosis and treatment plan to my other health care providers and insurance company if necessary.

Patient's Signature _____ Date _____

Guardian's Signature (if patient is under 18) _____ Date _____

Please bring the completed/printed form to your first appointment or email digitally filled out form to **info@kerryfamilydental.com** at least 24 hours prior to your appointment.



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient (if under 18): _____

Patient's Signature _____ Date _____

Guardian's Signature (if patient is under 18) _____ Date _____

CANCELATION POLICY

We want to be your partner not only in dental health, but in excellent overall health for many years to come. Any missed appointment may have a direct impact on your dental health. We respectfully ask that you give 24 business hours notice if you are unable to make your appointment so that we may reschedule your appointment as soon as possible as well as have time to fill the opening that you have created.

When you schedule your appointment unlike some other offices, we only schedule one patient at a given time. We respect your time and hope that you will do the same for us. Any "missed" appointment is one that you do not keep, or one that is not canceled or rescheduled within 24 business hours notice. A missed appointment has negative consequences both for your teeth and our practice by creating stress for us and an inconvenience for other patients. Therefore, if you miss an appointment you will be charged a fee of $60, for appointments for treatment valued at over $1,000 the charge will be 25% of the4 services that were to be rendered. We realize that rarely circumstances do arise that are beyond your control that may prevent you from keeping your appointment. Please let us know if there is anything we can do to help you keep your appointment.

I have read and understand the missed appointment policy set forth by Kerry Family Dental and agree to abide by it.

Patient's Signature _____ Date _____

INSURANCE BENEFITS

Your insurance benefit coverage is a contract between you and your insurance company. We will submit your claim to your insurance company for payment of any covered benefits. We will do our best to provide you with an estimate of your insurance benefits. Please remember that insurance estimates are subject to yearly maximums, fee scheduled, exclusions, copays, deductibles. Remember that dees quoted are only an estimate and not a guarantee of payment. Estimated copays are due at the time of services rendered.

If you do not have dental insurance, you are responsible for payment in full at the time of services rendered.

Patient's Signature _____ Date _____