Kelly Family Dentistry **Christian H. Kelly, DDS**

Patient Information

☐Married ☐ Single ☐ Divorced ☐ Widow

Name_____ Preferred Name_____ ☐ Male ☐ Female

Address_____ City_____ State_____ Zip_____

Social Security #_____ Birthdate_____ Email_____

Home #_____ Cell #_____ Work #_____

Employer_____ Address_____

Emergency Contact_____ Phone #_____ Relationship to Patient_____

Whom may we thank for referring you to our office_____

If the person responsible for this patient's account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled Insurance Information.

Responsible Party Name:_____ Relationship to Patient_____

Address_____

Social Security #_____ Birthdate_____ Email_____

Home #_____ Cell #_____ Work#_____

Employer_____ Address_____

PRIMARY INSURANCE INFORMATION

Policy Holder's Name_____ Relationship to Patient_____

Social Security #_____ Birthdate_____

Employer_____ Address_____

Insurance Co._____ Address_____

Group #_____ Member ID_____Phone_____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name_____ Relationship to Patient_____

Social Security #_____ Birthdate_____

Employer_____ Address_____

Insurance Co._____ Address_____

Group #_____Member ID_____ Phone_____

Signature of Patient or Responsible Party_____ Date_____

Time 5:05 PM | Kelly Family Dentistry, P.C. | Date 6/29/2015

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Financial Policy

Thank you for choosing Kelly Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Policy: In the effort to hold costs down, payment is due when services are provided. For your payment convenience, we accept Cash, Check, Visa, MasterCard and Discover.

Payment Options: For services exceeding $300, you may be interested in our no interest payment plan through Care Credit. This arrangement must be made ***prior*** to your appointment. Please note, lab related services such as crowns, bridges, partial and full dentures require 50% at the preparation date and 50% at the completion date. If you have insurance benefits, you may pay half of your portion at the start date and the remaining half when the service is completed.

Dental Insurance: As a courtesy to our patients who have dental insurance coverage, we will gladly file the claim electronically for you. ***Your deductible and co-payment are due the day of service***. We will figure these amounts for you using the information provided by your plan. This will include any amount that exceeds your annual maximum. Although we endeavor to be knowledgeable about the various insurance plans, it is your responsibility to know your policy benefits, limitations and exclusions. In the event the insurance claim is not processed within a timely manner, we will follow up with your carrier. However, further delays caused by the insurance company will require you to make full payment to our office. To expedite processing you will need to contact the insurance company directly. Your signature below indicates that the assignment of insurance benefits will be sent directly to our office. If the insurance company issues the payment directly to you, you will be responsible to make payment in full the day of service.

Finance Charge: A finance charge of 18% APR (or 1.5% MPR) will be automatically added to accounts that have a balance older than 30 days. Patient agrees to pay all cost of collection including but not limited to attorney fees, collection agency fees and court costs.

Broken Appointment Fee: Much time and preparation is invested in each appointment reserved. Last minute cancellations and no shows waste valuable time that could have been devoted to a patient in need especially for those who are having pain and discomfort. Therefore, we require 24 hours notice of cancellation. Failure to provide adequate notice of a change in schedule can result in a $50 Broken Appointment Fee.

Your signature below indicates that you have carefully read the preceding information and agree with the policies stated therein:

_____ _____

Signature of Patient or Guardian Date

_____

Patient Name (Please print)

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I give permission to share appointment, billing or dental information with the person(s) named:
(Please write each person's name below)

_____

_____

Print Patient Name_____

Signature_____

Relationship to Patient_____
(if patient is a minor)

Date_____

AUTHORIZATION TO CONTACT VIA MULTIMEDIA SERVICES

Our practice is updating your records to effectively stay in contact with our patients. Many of us today rely on cell phones, texting, and e-mail to keep up with our busy lifestyles. Several of our patients have stopped using their land lines completely.

Please use this form to let us know how you prefer to be contacted:

_____ Landline: _____

_____ Cell Phone: _____

_____ Texting: _____

_____ E-mail: _____

Patient Name _____

Address _____

_____

_____

Thank You!

Kelly Family Dentistry