Kelliher Family Dentists

Personal History

Name: Mr./Mrs./Miss_____ **DOB** ____/____/_____ **SS#**_____

Patient's Address _____

Home Phone _____ **Work Phone** _____ **Cell** _____

Email Address _____

Employed By _____

Name of Spouse _____ **Work Phone** _____

Person Responsible for Account _____

Referred By _____

Insurance Information

Insured Employee _____ **Social Security #** _____

Insured Date of Birth _____/_____/_____ **Relationship to Patient** _____

Employed By _____

Insurance Company Name _____

Insurance Company Address _____

Subscriber ID _____ **Group Number** _____

Office Policy

It is the policy of Kelliher Family Dentists to expect full payment in full at the time that services are rendered. Please be prepared to make payment at the time of your appointment. For your convenience, we accept most major credit cards as well as checks and cash.

If you choose to provide Kelliher Family Dentists with your insurance information, we will submit your claims to your insurance company. If you also assign benefits to Kelliher Family Dentists, we will *estimate* the amount of insurance coverage and charge to you the "patient portion" at the time that services are rendered. Insurance coverage is a contract between you, the patient, and your insurance company. Kelliher Family Dentists will attempt to do everything possible to ensure that you the patient receives maximum benefits. It is ultimately, however, the responsibility of the patient to ensure proper and prompt payment from the insurance company. Correspondingly, Kelliher Family Dentists reserves the right to demand the immediate payment of any outstanding balance, regardless of any outstanding insurance claims. The patient accepts responsibility for any charges accrued during the process of collecting any outstanding balance. I authorize the release of any information relating to dental claims.

Kelliher Family Dentists require a minimum of <u>twenty-four</u> (24) hours notice for an canceled appointment.

I have read and agree to comply with the office policy of Kelliher Family Dentists.

Signature _____ **Date** _____

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Medical History

Name _____ **Sex M / F Date of Birth** _____

Name of your Physician _____ **Phone** _____ **Last Seen** _____

Name of Specialist (If applicable) _____ **Phone** _____

Are you currently experiencing any medical problems? (Explain) _____

Are you taking any medicines now? List _____

Have you ever had a serious bleeding or bruising problem associated with extractions, surgery, or injury? Y / N

Explain _____

Are you allergic, sensitive, or had a reaction to any drugs, medicines, or injections? (Such as penicillin, sulfa, novocaine, aspirin, codeine, iodine, or any other substance such as latex)?

List _____

Have you ever been treated for alcohol and/or drug abuse? Y / N

Have you ever tested positive for HIV/AIDS? Y / N

Have you ever been hospitalized for serious illness/injury? Y / N Explain _____

Have you ever had serious injuries/surgery of the head/face/jaw? Y / N

Have you ever had Hepatitis or Jaundice? Y / N
Have you taken within the last 5 years—Biphophonates Y / N

i.e. Fosomax, Boniva, Actonel?

Do you have a prosthetic joint/implant? Y / N Describe _____

Do you consider yourself to be in good health? Y / N

Are you pregnant? Y / N Delivery date _____

Circle any of the following conditions you have had or been treated for:

Heart Condition/Attack	Rheumatic Fever	Asthma/Hay Fever	Diabetes	Syphilis/VDs
Congenital Heart Defect	Thyroid Condition	Heart Murmur	Tuberculosis	Heart Surgery
Arthritis/Rheumatism	Malignancy/Cancer	Lung Condition	Anemia	Sinus Condition
High/Low Blood Pressure	Kidney Condition	Fainting Spells	Ulcer	Epilepsy
Stomach Condition	Liver Condition	Skin Condition		

Please describe any other condition or problem not listed above which may be of concern to you or the Doctor_____

When was your last dental visit? _____ Are you experiencing any problems now? Y / N
Have you ever had problems associated with previous dental treatment? Y / N
Are you happy with your smile? Y / N

Signature _____ **Date** _____