KODAK DENTAL CARE WELCOMES YOU TO OUR PRACTICE

PATIENT INFORMATION

(PLEASE PRINT)

Date ______________

Patient____

Last Name First Name Middle Initial

Street Address ____

City____________________ State____ Zip_______ TN License _______________Exp Date_________

Home Phone______________ Work Phone________________ Cell_____________________

Sex (M) ___ (F)___ Age_____ Birthdate ______________SS#______________________________

Married ___ Widowed___ Single___ Minor___ Separated ___ Divorced ___

Employer/School _____________________________Employer Phone ____________________________

Employer/School Address____

E-mail Address ____

Pharmacy Name______________________________ Phone number_(______)____________________

RESPONSIBLE PARTY INFORMATION

(IF DIFFERENT FROM PATIENT)

Responsible Party______________________________ Relationship to Patient_____________________

Birthdate _____________________ SS#_________________________M__W__S__SEP__D_________

Home Phone______________ Work Phone________________ Cell_____________________

Street Address ____

City__________________ State____ Zip_______ TN License _______________Exp Date___________

Employer/School_____________________________ Employer Phone ______________________________

Employer/School Address____

POLICY HOLDER INFORMATION

(INFORMATION ON THE PERSON THAT CARRIES THE INSURANCE)

Insured Name ____Insured Birthdate ___________________

Insured Employer ____

Employer Address _______________________________________Phone __________________________

Insured Social Security #________________________ Insured ID# ______________________________

Dental Insurance Company __________________________________Group Number________________

In case of emergency, who should be notified? ____

Phone Number (_____) __________Whom may we thank for referring you? _________________________

HEALTH HISTORY FOR DENTAL SERVICES

Patient's Name: ____
(First) (Middle) (Last) (Date of Birth) (Age) (Social Security Number)

Home address:____
(Street) (City) (Zip Code) (Telephone)

1. What kind of dental problem do you have?
____
____

2. Has there been any change in your health within the past year? --Yes __ No__

3. Are you under the care of a physician ------------ Yes __ No__

4. The name and phone number of my physician is:
____

5. Have you had any serious illness, accident or operation? ---Yes __ No__
If so, what was the illness, accident or operation:
____

____

6. Are you required to PRE-MEDICATE before any dental treatment? YES _____NO______
If YES, reason_____________________

7. Do you have or have you had the following diseases or problems:
a) Rheumatic Fever or Rheumatic heart disease. Yes __No __
b) Congenital Heart Lesions --------------------------Yes __No __
c) Cardiovascular Disease
1) Heart Attack ---------------------------------------Yes __ No __
2) Heart Trouble --------------------------------------Yes __ No __
3) Coronary Insufficiency---------------------------- Yes __ No __
4) Coronary Occlusion--------------------------------Yes __ No __
5) High Blood Pressure ------------------------------Yes __ No __
6) Arteriosclerosis-------------------------------------Yes __ No __
7) Stroke --Yes __ No __
8) Heart Murmur-------------------------------------Yes __ No __
9) Mitral Valve Prolapse--------------------------- -Yes __ No __
d) Asthma or Hay Fever-------------------------------Yes __ No __
e) Fainting spells or seizures--------------------------Yes __ No __
f) Diabetes Type 1____Type2____-------------------Yes __ No __
g) Hepatitis A____B____C_____ -------------------- Yes __ No __
h) Liver Disease --------------------------------- ------- Yes __ No __
i) Tuberculosis--- Yes __ No __
j) Venereal Disease------------------------------------- Yes __ No __
k) Human Immune Deficiency Virus (HIV/AIDS) Yes __ No __
l) Other____
____

8. Have you ever had abnormal bleeding associated with previous extractions, surgery, or trauma? – Yes __No__
a) Have you ever required a blood transfusion?Yes _No__
b) Do you have a blood clotting disorder----------Yes _No__
If so, explain: ___________________________________

9. Have you had radiation treatment for a tumor, or other condition of your mouth or lips? -----------------Yes--No

10. Do you take any blood thinners? ----------------Yes__No____
Do you take any bisphosphonates?---------------Yes__No____
Please list all medications:____________________________
____
____
____

11. Are you allergic or have you reacted adversely to:

a) Local anesthetics ----------------------------Yes __ No

b) Penicillin or Amoxicillin --------------------Yes __ No
c) Sulfa drugs -----------------------------------Yes __ No __
d) Barbiturates, sedatives, or sleeping pills Yes __ No __
e) Aspirin ---------------------------------------Yes __ No __
f) Iodine ---Yes __ No __
g) Codeine ---------------------------------------Yes __ No __
h) Latex --Yes __ No __
i) Other ______________________________________

12. Do you have any disease, condition or problem not listed above that you should let us know about? --Yes __ No __
If so, please explain ______________________________
____
____

WOMEN

13. Are you pregnant? -------------------------------Yes __ No __

CHILDREN

14. Any prenatal or birth complications? ------- Yes __ No _
If yes please explain: ____________________________

15. List any history of tobacco, alcohol or drug use:
____
____

To the best of my knowledge, the forgoing medical history questions have been accurately answered.
Name______________________________________ Relationship to patient _________________________

Signature____Date ____________________

Dentist Signature____ Date_________________
Reviewed by Assistant _______ Date __________ Assistant ________ Date ___________ Assistant _______ Date ______________
Initial **Initial** **Initial**

Kodak Dental Care

Your Privacy Is Important to Us

Acknowledgement of Notice of Privacy Policies

If requested, I may receive a copy of the Notice of Privacy Practices of Kodak Dental Care, PLLC. I hereby authorize, as indicated by my signature below, Kodak Dental Care to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_________________________________ _________________________________
Patient's Name Signature (Guardian if patient is a minor)

____
Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____________________________

☐ You may contact me on my mobile telephone number ____________________________

☐ You may contact me on my work telephone number _____________________________

☐ You may send me an email at: ____

☐ Other ____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. ____Date Added / Removed:__________

2. ____Date Added / Removed: __________

3. ____Date Added / Removed: __________

4. ____Date Added / Removed: _________

5. ____Date Added / Removed: _________

For Office Use Only:
We attempted to obtain written acknowledgement of our Notice of Privacy Practices,
but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) ____

Staff Person Initials ___________

PATIENT CONSENT

Clinical

I authorize the dentists of Kodak Dental Care to perform all recommended treatment.

I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Broken Appointment Policy

Because reserved appointments require operatory and staff assignment, equipment and instrument setup along with administrative and/or insurance pre-planning, ***please pay close attention to the following requirements:***

- ***We do require a 24 hour business day notice when an appointment has to be cancelled or rescheduled.***
- ***We will ask you to confirm your appointment. Please do so when prompted through the messaging system or you may phone the office.***

We do reserve the right to charge for a broken appointment. After two missed appointments per family, the family is subject to dismissal from the practice.

Insurance

I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

Financial

I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's or Guardian's (if minor) Signature: ________________________ Date: ____________