Kirchner Dental
COMPREHENSIVE DENTAL SOLUTIONS

Patient Information

Patients Name:_____ Preferred name: _____
Please circle one of the following: Married Single Separated Divorced Widowed
Sex: M / F DOB: _____ Age: _____ SSN: _____
Home Address:_____
City: _____ State:_____ Zip:_____
Home phone #: _____ Cell #: _____ Work #:_____
Email address: _____
Your Employer: _____Occupation: _____
Work Address: _____
How did you hear about our office?_____

Dental History

What are your dental concerns?_____
Are you having pain at this time? Yes No
If yes, where is your pain? _____ How long has it been there? _____
What is the name of your previous dentist?_____
When was your last visit? _____Was all treatment completed? Yes No
Are you afraid of dental treatment? Yes No
Have you ever been diagnosed with any form of gum disease? Yes No
If yes, what kind? _____
Are your teeth sensitive to hot, cold, sweet or sour? Yes No
Do you Clench or grind your teeth when sleeping or while awake? Yes No
Do your jaws get sore, tired, pop, catch or lock? Yes No

Check the box if you have had any of the following:

☐ Root canal treatments	☐ Wisdom teeth extracted	☐ TMJ therapy
☐ Partial dentures	☐ Complete dentures	☐ Broken jaw
☐ Facial injuries	☐ Gum surgery/ treatment	☐ Sleep apnea
☐ Crowns	☐ Fixed bridges	☐ Implants
☐ Braces	☐ Whitening	

I would like more information on (circle):

Tooth whitening clear aligners Missing teeth replaced Implants
Dentures Smile improvement Porcelain veneers

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Health History

Your Physician's name:_____ Last medical exam: _____

Physician's phone #: _____ Are you under active medical care? Yes No

Rate your general health: Poor Fair Good Excellent

Circle any of the following that you have had or have present:

Alcoholism	Cortisone medicine	Heart surgery	Pain in jaw joints
Arthritis/ Rheumatism	Diabetes	Hepatitis A (infectious)	Psychiatric treatment
Artificial heart valve	Drug addiction	Hepatitis B (Serum)	Radiation therapy
Artificial joint	Emphysema	Hepatitis C	Replacement valve
Asthma/ Hay fever	Epilepsy/ Seizures	High blood pressure	Rheumatic fever
Blood transfusion	Fainting/ Dizzy spells	HIV Positive/ AIDS	Shortness of breath
Bruise easily	Genital Herpes	Kidney trouble	Skin rashes/ hives
Cancer or Tumor	Glaucoma	Latex sensitivity	Stroke
Chemotherapy	Heart attack	Liver disease	Swelling of ankles
Chest pains	Heart condition	Lung disease	Tuberculosis (T.B.)
Cold sores	Heart pacemaker	Metal sensitivity	Thyroid disease
			Venereal disease

Other: _____

Have you had a bad reaction to local anesthetic? Yes No

Have you had prolonged or unusual bleeding or bruise easily? Yes No

Do you smoke? Yes No How much? _____ How often? _____

Do you use smokeless tobacco? Yes No

Please list any medications you take (Prescription & over the counter):

_____

_____

Pharmacy name & location:_____

Please list any medicine, drug or other substance you are **ALLERGIC** to:

_____

Women Only

Are you currently pregnant? Yes No Due date:_____

Do you use birth control or implants? Yes No

Do you anticipate becoming pregnant? Yes No

Any complications with a previous pregnancy? Yes No

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Dental Insurance Information

Subscribers name: _____ Relationship to patient: _____
Dental insurance company: _____ Phone #:_____
Dental insurance company address:_____
_____
Subscribers Employer:_____Subscriber ID:_____ Group # _____
Subscribers SSN: _____ Subscribers DOB: _____

Parent/Guardian Information (If patient is a minor)

Name _____ Relationship to patient: _____
Phone #_____ DOB:_____ SSN: _____
Address: _____ ☐ Same address as patient
_____

Emergency Contact

Name:_____ Phone #: _____
Relationship:_____ Address: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ANOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THE INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received (by request) a copy of this office's Notice of Privacy Practices.

You may refuse to sign this acknowledgement

I understand I have the opportunity to ask questions and receive satisfactory and adequate explanations.

_____ _____
Patient name (PLEASE PRINT) Date

_____
Patient/ Guardian Signature

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Patient Financial Consent

Payment is due at the time of service. We ask that you pay the deductible and the co-payment, which is the estimated charge not covered by your insurance company by cash, personal checks, MasterCard, Visa, American Express, Discover or Care Credit.

Please note returned checks will be subject to additional fees. In the case is becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred, along with any charges associated with those agencies and/or finance charges.

Insurance payments are ordinarily received within 30-60 days from the time of filing. If payment has not been received by your insurance company within 30 days, we ask that you contact your insurance company to make sure payment is expected soon. If payment is not received after 60 days or your claim is denied, you will be responsible for paying the full amount at that time.

We will cooperate fully with the regulations and request of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Insurance

I authorize Kirchner Dental to release to staff, hospitals, healthcare service plans, insurance companies, self-insurers or their representatives all information, records and other diagnostic materials about my medical history, and services rendered or recommended treatment.

I authorize Kirchner Dental to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company on 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.

As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly what is estimated. Your insurance company and your plan benefits ultimately determine the amount paid.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as you dental care provider. Our relationship is with you, our patient, not your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Our office is not a party to that contact. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company arbitrary determination of usual and customary rates.

I have read this patient consent and agree to all terms and conditions herein.

X_____ Date: _____