Dentistry Revolution
Keith G. Kordsmeier, DDS

WELCOME

New Patient Data Date: _____

Patient Name: Last_____ First_____ MI_____

What you prefer to be called: _____ Male _____Female_____

Birth Date:____/____/____ Age:_____ SS#_____

Mailing Address:_____

_____

City State Zip

Home Phone #:_____ Cell #:_____

Work Phone #: _____Ext_____

E-mail Address:_____

Referred By: _____

Employer: _____How Long?_____

Employer's Address: _____

_____

Occupation: _____

Status: Minor__ Single__ Married__ Divorced__ Separated__ Widowed____

Spouse's Name:_____

Patient Name: _____

ACCOUNT INFORMATION:

Person Responsible For Account:

Name:_____

Relation to Patient: _____

Mailing Address: _____

_____

SS#: _____

Drivers License #: _____

Work Phone #: _____

Cell Phone #: _____

Payment Method: Cash _____ Check _____

Credit Card #:_____

Patient Name: _____

INSURANCE DATA:

Primary Dental Insurance (can scan card data into our system)

Company Name: _____

Address: _____

_____

Phone #: _____

Insured's Name: _____

Insured's SS #: _____

Insured's Date of Birth: _____

Insured's Employer: _____

Group # (Plan, Local, or Policy #): _____

Relation to Patient: _____

_____ (initial) **I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid for by my insurance company.**

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation? _____

Home Phone # or Cell#: _____

Work Phone #: _____

Who is your medical doctor? _____

M.D.'s Phone #: _____

Patient Name: _____

MEDICAL HISTORY: DATE _____

ALLERGIES (medication and other causes): _____

_____

Medications that you currently take (including herbal supplements):

_____

_____

_____

_____

_____

_____

Date of Last Physical Exam: _____

Name of Primary Care Physician: _____

Do you have or ever had any of the following diseases or medical conditions? Mark space to the left with a + if you have a history of this condition.

_____Heart Attack
_____Stroke
_____Prosthetic Heart Valve
_____Congenital Heart Disease
_____Heart Disease
_____Previous Infectious Endocarditis
_____Heart Transplant
_____Heart Surgery /pacemaker history
_____Coronary Artery Stents
_____Total Joint Replacement (date of surgery; previous joint infection?)
_____Bleeding problems (take medication that thins blood? Hemophilia?)
_____Hypertension (High Blood Pressure?)
_____Angina (Chest Pains)
_____Arrhythmias (abnormal rhythms of heart?)
_____Diabetes (Insulin dependent?)
_____Congestive Heart Failure

Patient Name: _____

_____Tobacco Use
_____Alcohol Use
_____Immunosuppression (spleen removed, medication caused or disease related)
_____Systemic Lupus Erythematosus (SLE)
_____Rheumatoid Arthritis (RA)
_____Anxiety
_____AIDS/HIV
_____Cancer (Radiation and/or Chemotherapy?)
_____Asthma
_____Hepatitis
_____Liver problems
_____Kidney problems
_____Respiratory problems (Emphysema?)
_____Stomach problems (ulcer?)
_____Reflux (GERD?)
_____Colitis (Crohns Disease?)
_____Psychiatric problems
_____Neurological Disorder
_____Alcohol/Drug abuse
_____Venereal Disease
_____Tuberculosis (TB)
_____Sinus problems
_____TMJ/ Jaw injury and/or pain
_____Shingle history
_____Arthritis
_____Fainting/Seizures/Epilepsy
_____Headaches (severe/frequent?)
_____Neck pain
_____Back Problems
_____Glaucoma
_____Anemia
_____Pregnant
_____Please list any other Medical Condition that has not been listed that you may have had previously diagnosed:

_____

_____

_____

_____

Patient Name: _____

Dental History:

Date of Last Dental Exam? _____
Previous dentist? _____
History of dental X-Rays taken in past three years? _____
_____

_____Premedication with antibiotics for dental visits in past?
_____Allergy to dental anesthetics? (Lidocaine?)
_____History of any complication as the result of dental injections? (Paresthesia?)
_____Allergy to any dental materials? (Latex? Nickel? Acrylic?)
_____Periodontal disease history?
_____Orthodontic History?
_____Wisdom teeth removed?
_____Wear a Dental Prosthesis?
_____Facial trauma?
_____TMJ /Jaw problems/clicking or popping?
_____Clench or Grind teeth?
_____Oral sores in past?
_____Cold sores in past?
_____Dental Anxiety?
_____Dry Mouth?
_____Bad breath concerns?
_____Cosmetic dental improvements? (Whitening?, Veneers? Other?)
_____Please describe you current home care techniques:
_____
_____
_____Oral Cancer? (Screening?)
_____Any particular mouth habits? (lip, cheek or tongue biting, foreign objects between teeth, etc? _____
_____Other history that you would like to inform us of would be appreciated:
_____
_____
_____
_____

DENTIST SIGNATURE: _____

DATE: _____

Patient Name: _____

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you a copy of "Notice of Privacy Practices" for this office. By signing below you are indicating that you have received a copy of the "Notice of Privacy Practices" for this practice and realize that you may call the office regarding such practices at any time.
Your dental records will be maintained in a digital format with any hard copies of your data locked up nightly. We use password protected access for all computer data and have a contract with a dental IT company to maintain a secure server.

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

The following person or persons have my permission to have access to my dental record and I will allow the Doctor to discuss my dental care with the following individuals:

_____

_____

Signature and Date: _____

We want to communicate with our patients in a manner that best fits their needs. Please indicate which method we should use to confirm appointments:

_____Phone contact ?

_____E-mail message?

_____Text message on your mobile?

_____Leave a message on home phone?

_____Leave a message on work phone?

_____Leave a message with spouse/secretary/other?

_____Other method that is not listed?

Patient Name: _____

FINANCIAL POLICY

Our policy requires payment in full for all services rendered at the time of visit, unless arrangements have been made with the office. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims for these services.

Patients are requested to provide 48 hour notice of any change in their appointment. Failure to notify the office of changes may result in a fee of $25.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to this information I have provided.

SIGNATURE: _____ DATE: _____

UPDATED: 10/27/08 KK