

PATIENT INFORMATION

(PLEASE PRINT ALL INFORMATION CLEARLY)

Name _____ Married Widowed Single Child
Street Address _____
City _____ State _____ Zip _____
Home Phone () _____ Work Phone () _____
Birth Date _____ Social Security # _____
Employer _____ Employer's Address _____
cell # _____

PERSON RESPONSIBLE FOR PAYMENT: Patient Spouse Parent Guardian

Name _____
Street Address _____
City _____ State _____ Zip _____
Home Phone () _____ Work Phone () _____
Birth Date _____ Social Security # _____
Employer: _____ Employer's Address _____
Method of Payment: Cash _____ Insurance _____ Dual insurance _____

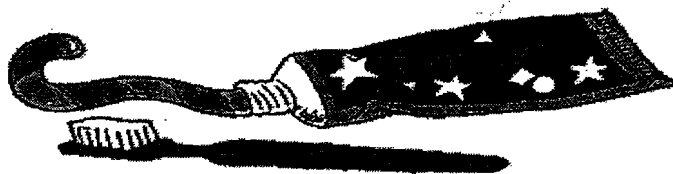
Is there another person responsible for this account? _____
Name Social Security #

DENTAL INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insured		
Insurance Company		
Insurance Company Address		
Employer		
Group Number/ Date of Birth		

PERSON TO CONTACT IN CASE OF AN EMERGENCY: _____
Name Phone

HOW DID YOU FIND OUT ABOUT OUR OFFICE: _____



Turn to the next page



I hereby authorize payment directly to Dr. Kendrick of the group insurance benefits otherwise payable to me. I hereby authorize Dr. Kendrick to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I authorize Dr. Kendrick to release any information required by him to my insurance company. The information I have provided for this chart is true and correct to the best of my knowledge. A 1½ % per month charge will be added to accounts 90 days past due (annual rate 18%). I agree that if I do not meet my financial responsibility I will be responsible for finance &/or collection charges as they apply. I understand fees are subject to change without prior notice.

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. **The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Patient Name: _____

Signature of Patient or Guardian: _____ Date : _____

Relationship to Patient (if other than patient): _____

IF PATIENT IS A CHILD:

_____ Yes, I authorize the use of my child's name and picture in the "NO CAVITY CLUB".

_____ No, I do NOT authorize the use of my child's name and picture in the "NO CAVITY CLUB".

PLEASE CHECK YES OR NO

1. Are you presently in pain? YES NO
 Teeth Jaw Gums Face Other
2. Have you lost any permanent teeth, other than wisdom teeth? YES NO
If the teeth were replaced, how? _____
3. Is any part of your mouth sensitive to the following? YES NO
 Hot Cold Pressure Sweet Sour Other
4. Do you have any burning sensation in your mouth? YES NO
5. Have you experienced unusual dryness of the mouth? YES NO
6. Have you ever had gum surgery or been treated for gum disease? YES NO
If yes, when? _____ By whom? _____
7. Do your gums bleed when you brush your teeth? YES NO
8. Does food catch between your teeth? YES NO
9. Are you aware of a bad taste or odor in your mouth? YES NO
10. Are you aware of any growths or swelling in your mouth? YES NO
11. Are you aware of your jaw clicking, popping or making grating-like noises; or do your jaw muscles feel tired, stiff or painful? YES NO
12. Do you clench or grind your teeth during the day or night? YES NO
13. Are you dissatisfied with the appearance of your teeth? YES NO
If YES, what would you like most to change? _____
14. Are you anxious or nervous about dental treatment? YES NO
15. Have you had any unpleasant dental experiences? YES NO
Please explain: _____
16. Are you interested in learning how to control dental disease to preserve your teeth & oral health? YES NO
17. Do you have any questions or concerns? YES NO
If yes, please explain: _____
18. When was the last time you saw a dentist? _____
19. How long has it been since you had your teeth cleaned? _____

DENTAL HISTORY

The following health history questions are designed for your benefit and safety. Your complete answers will assist us in treating you with consideration for your special needs.0

Family Physician _____

Date of last visit _____ Phone () _____

PLEASE CHECK YES OR NO

1. Do you have a current medical problem or condition, and if so, are you currently under the care of a physician? YES NO

2. Have you been hospitalized or have you had a serious illness within the last five years? YES NO

3. Do you have heart trouble or any form of cardiovascular disease (please X known conditions)? YES NO

- | | | |
|--|---|---|
| <input type="checkbox"/> Angina/ Chest pains (frequency _____) | <input type="checkbox"/> Rheumatic Fever (date _____) | <input type="checkbox"/> Bypass |
| <input type="checkbox"/> Heart Attack (date _____) | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Arteriosclerosis |
| <input type="checkbox"/> Heart Surgery (date _____) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prosthetic Heart Valve |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Mitral Valve Defect | <input type="checkbox"/> Stroke (date _____) | <input type="checkbox"/> Other _____ |

4. Please list any medications you have taken in the last year: _____

5. Do you or have you ever had any of the following (please X known conditions)?

- | | | |
|--|--|--|
| <input type="checkbox"/> Hepatitis (date ____ / type ____) | <input type="checkbox"/> Chronic Head, Neck or Back Pain | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> AIDS or ARC | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Stomach or Intestinal Ulcers | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Sinus Trouble/ Hay Fever | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Artificial Joint, Limb or Implant | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma |

6. Have you ever taken preventive antibiotics prior to dental treatment due to a medical condition such as a joint replacement, heart murmur, valve defect, etc. ? YES NO

7. Are you allergic to or have you had any unusual reaction to any drugs or medicines? YES NO
If YES, please list: _____

8. Have you had surgery, radiation or other treatment for a tumor or growth? YES NO

9. For women: Are you currently pregnant or think you might be? YES NO

The above medical information is correct to the best of my knowledge. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment by the doctor. I understand the responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Signature _____ Date _____

MEDICAL HISTORY

Dr Samuel D. Kendrick DMD
Dr Timothy Jones DMD
1226 Ledlie Ave
Springfield, Il 62702

Name _____

Date _____

1) Are you currently taking, or have you ever taken?

Etidronate	(Didronel)	Yes	No
Tiludronate	(Skelid)	Yes	No
Alendronate	(Fosamax)	Yes	No
Residronate	(Actonel)	Yes	No
Ibandronate	(Boniva)	Yes	No
Pamidronate	(Avedia)	Yes	No
Zoledronate	(Zometa)	Yes	No

2) Are you currently taking or have you ever taken any medications for osteoporosis, pagets syndrome or metastatic cancer?