KEARBEY
DENTAL GROUP

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____
Last *First* *M*

Gender: _____ Marital Status: ☐ Married ☐ Single Email Address: _____

Birth Date: _____ Social Security #: _____ Driver's Lic. #: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____ Relationship to Patient: _____

HEALTH INFORMATION

Date of Last Dental Visit: _____ Reason for This Visit: _____

Have you ever had any of the following? Please check YES or NO. If yes, please explain below.

Alcohol/Drug Abuse	☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Joints/Valves	☐ Yes ☐ No	Heart Attack/Surgery	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease/Transfusions	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cancer/Chemo/Radiation	☐ Yes ☐ No	Hepatitis A B C	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	Herpes/Fever Blister	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Coumadin Therapy	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Do you smoke/chew?	☐ Yes ☐ No
Depression	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Do you grind your teeth?	☐ Yes ☐ No
Diabetes: Insulin/Pills/Diet	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Do you snore?	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		

If yes, please explain: _____

Are you allergic to any of the following? Please check YES or NO:

Clindamycin	☐ Yes ☐ No	Dexamethasone	☐ Yes ☐ No	Phenergan	☐ Yes ☐ No	Fentanyl	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Latex	☐ Yes ☐ No	Sulfa	☐ Yes ☐ No	Valium	☐ Yes ☐ No
Demerol	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No	Versed	☐ Yes ☐ No	Other(s):	_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician: _____ Physician's Phone Number: _____

Women: Are you taking birth control: ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you currently Pregnant? ☐ Yes ☐ No

Please list any MEDICATIONS that you are currently taking and for what condition: _____

_____

_____

REFERRAL INFORMATION

How did you hear about our practice? _____

Names of other family members seen in our office: _____

OFFICE USE ONLY

Reviewed by Dr. _____ Date: _____

EMPLOYMENT INFORMATION

Employer Name: _____

Phone: _____ Occupation: _____

Employer Address: _____

Street *City* *State* *Zip*

INSURANCE INFORMATION

Primary Insurance Company: _____ Group #: _____ Effective Date: _____

Secondary Insurance Company: _____ Group #: _____ Effective Date: _____

CONSENT FOR TREATMENT

Welcome to our office! Thank you for choosing us as your dental care provider. In order to better serve your needs, we feel it is important for you to understand our financial policy and our standard practices. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Our practice is committed to providing the best treatment for our patients and our charges reflect what is usual and customary for our area.

"Please help us to serve you better by keeping scheduled appointments. All minors under the age of 18 years must be accompanied by an adult. We request providing advanced notice if changes are needed to an appointment. A 24hr notice is required and cancellations/missed appointments are subject to a $50 reservation fee. After 2 missed appointments, we reserve the right to dismiss the patient from our practice."

We will be happy to provide you with an estimate for the treatment needed, however, this is simply an estimate and may not always be accurate. In some cases, when work is started, there are unseen repairs and/or conditions discovered, which could not be detected at the time of the original estimate. We must therefore assume no liability to perform services for prices quoted in original estimates and those prices are subject to change.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. We will bill your insurance as a courtesy. We require that you provide the dental insurance information and advisement of subsequent insurance changes or requests. Your insurance policy is a contract between you and your insurance company. A finance charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X: _____ Date: _____ Relationship to Patient: _____

Signature of Patient/Guardian/Responsible Party

HIPAA PATIENT CONSENT

Kearbey Dental Group
2690 Olive Highway Oroville, CA 95966

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing that I have received this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third-party payers (e.g., my insurance company)
- The day-to-day healthcare operations at your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices. It contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations. You are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclose that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____ DOB: _____

Signature: _____ Date: _____