Sugarhill Dental

Christopher W. Kindig, D.M.D.

Melissa C. *Kindig, D.M.D.*

PATIENT INFORMATION FORM

PATIENT NAME _____ NICKNAME _____ DATE _____

LOCAL ADDRESS _____ CITY _____ ZIP _____

ALT. ADDRESS _____ CITY/STATE _____ ZIP _____

HOME PHONE ( ) _____ CELL PHONE ( ) _____

DATE OF BIRTH _____ / _____ / _____ AGE_____SEX _____ MARITAL STATUS _____

SOCIAL SECURITY # _____ SPOUSE'S NAME _____

REFERRED BY _____

EMAIL _____

EMPLOYER NAME _____ WORK PHONE ( ) _____

EMPLOYER ADDRESS_____

PARENT/ LEGAL GUARDIAN (IF PATIENT IS A MINOR) _____

IN CASE OF EMERGENCY (CLOSEST RELATIVE OR FRIEND)

NAME _____ RELATIONSHIP _____ PHONE NUMBER _____

FAMILY PHYSICIAN _____ OFFICE PHONE _____

DENTAL INSURANCE PLAN NAME _____ ID# _____PHONE# _____

POLICY HOLDER'S NAME _____ D.O.B _____

MEDICAL HISTORY FORM

PATIENT NAME _____

DO YOU HAVE ANY INFLAMED AREAS. GROWTHS OR SORE SPOTS IN OR AROUND YOUR MOUTH? **YES NO**

IF YES. DESCRIBE _____

ARE THERE ANY CHANGES IN YOUR HEALTH IN THE PAST YEAR? **YES NO**

EXPLAIN _____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN'? **YES NO**

NAME OF PHYSICIAN _____ PHONE NUMRER _____

HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST 5 YEARS? **YES NO**

IF YES, EXPLAIN _____

HAVE YOU HAD ABNORMAL BLEEDING WITH PREVIOUS EXTRACTIONS, SURGERY OR TRAUMA? **YES NO**

HAVE YOU EVER TESTED POSITIVE FOR HIV INFECTION OR AIDS? **YES NO**

HAVE YOU EVER HAD SURGERY AND/OR RADIATION FOR A TUMOR, GROWTH OR OTHER CONDITION? **YES NO**

IF SO, PLEASE STATE THE DATE OF DIAGNOSIS AND TREATING PHYSICIAN _____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE ONE)

HIGH BLOOD PRESSURE	YES NO	STOMACH ULCERS, COLITIS	YES NO
HEART MURMUR OR **MVP** (CIRCLE)	YES NO	HEPATITIS, JAUNDICE, LIVER DISEASE	YES NO
DIABETES	YES NO	KIDNEY PROBLEMS	YES NO
JOINT PROSTHESIS (HIP, KNEE, ETC.)	YES NO	PSYCIATRIC PROBLEMS	YES NO
RHEUMATIC HEART DISEASE OR FEVER	YES NO	FAINTING PROBLEMS	YES NO
CONGENITAL HEART DISEASE	YES NO	EPILEPSY	YES NO
CARDIOVASCULAR DISEASE, HEART ATTACK, STROKE OR BYPASS	YES NO	CANCER IF YES, WHAT TYPE	YES NO
PROSTHETIC HEART VALVE	YES NO	LOW BLOOD PRESSURE	YES NO
BLOOD DISORDER (E.G. ANEMIA)	YES NO	DO YOU SMOKE/AMOUNT	YES NO
VENEREAL DISEASE	YES NO	TEMPOROMANDIBULAR JOINT PROBLEMS (TMJ)	YES NO
ASTHMA	YES NO	LOW BLOOD SUGAR	YES NO
CHEST PAIN, ANGINA	YES NO	DIALYSIS	YES NO
SWOLLEN ANKLES ARTHRITIS OR JOINT DISEASE (CIRCLE ONE)	YES NO	HAVE YOU EVER HAD AN EPISODE OF INFECTIVE ENDOCARDITIS	YES NO
CARDIAC PACEMAKER	YES NO	CONTAGIOUS DISEASES	YES NO
HEART SURGERY	YES NO	BRONCHITIS, CHRONIC COUGH	YES NO
DELAY IN HEALING	YES NO	HAY FEVER OR SINUS PROBLEMS	YES NO
TUBERCULOSIS	YES NO	PROBLEMS WITH THE IMMUNE SYSTEM	YES NO
EMPHYSEMA	YES NO	DIFFICULTY BREATIIING/LUNG TROUBLE	YES NO
RADIATION OR CHEMOTHERAPY	YES NO	CHRONIC FATIGUE OR NIGHT SWEATS	YES NO
ON A DIET	YES NO	HISTORY OF DRUG ABUSE	YES NO
HISTORY OF ALCOHOL ABUSE	YES NO	IRREGULAR HEARTBEAT	YES NO
EYE DISEASE OR GLAUCOMA	YES NO	BRUISE EASILY	YES NO

DO YOU REQUIRE ANTIBIOTIC PRE-MEDICATION PRIOR TO ALL ROUTINE DENTAL WORK? YES NO

REASON FOR PRE MEDICATION _____ ANTIBIOTIC USED? _____

ARE YOU TAKING OR HAVE YOU TAKEN BISPHOSPHONATE MEDICATION, SUCH AS ACHRONAL, RECLAST OR FOSAMAX WITHIN THE PAST TWELVE YEARS? YES NO

ARE YOU ALLERGIC TO OR HAVE HAD ANY PROBLEMS WITH: (PLEASE CIRCLE ONE)

PENICILLIN	YES NO	IF YES, PLEASE EXPLAIN _____
OTHER ANTIBIOTICS	YES NO	IF YES, PLEASE LIST _____
CODEINE	YES NO	IF YES, PLEASE EXPLAIN _____
ASPIRIN	YES NO	IF YES, PLEASE EXPLAIN _____
NSAIDs (I.E. ADVIL, ALEVE)	YES NO	IF YES, PLEASE EXPLAIN _____
DENTAL ANESTHESIA	YES NO	IF YES. PLEASE EXPLAIN _____
LATEX	YES NO	IF YES, PLEASE EXPLAIN _____

OTHER _____

DO YOU TAKE ANY MEDICATI0N, INCLUDING NON-PRESCRIPTION? YES NO

IF YES. PLEASE LIST AND GIVE REASON FOR TAKING (OR ATTACH LIST)

_____

_____

DO YOU TAKE VITAMIN/HERBAL SUPPLEMENTS? YES NO

IF YES, PLEASE LIST AND GIVE REASON FOR TAKING (OR ATTACH LIST)

_____

IS THERE ANYTHING ELSE IN YOUR MEDICAL HISTORY OF SIGNIFICANCE? _____

_____

FOR FEMALE PATIENTS ONLY

IS THERE A POSSIBILITY THAT YOU ARE PREGNANT?	YES NO	DUE DATE: _____
ARE YOU NURSING?	YES NO	
ARE YOU CURRENTLY TAKING BIRTH CONTROL?	YES NO	

PLEASE NOTE: ANTIBIOTICS (SUCH AS PENICILLIN) MAY ALTER THE EFFECTIVENESS OF MANY FORMS OF BIRTH CONTROL. CONSULT YOUR PHYSICIAN/ GYNECOLOGIST FOR ASSISTANCE REGARDING ADDITIONAL METHODS OF BIRTH CONTROL.

PATIENT SIGNATURE _____ DATE: _____
(PATIENT OR LEGAL GUARDIAN SIGNATURE)

PLEASE PRINT PATIENT NAME _____

SUGARHILL DENTAL

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Melissa C. Kindig, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received or been given the opportunity to read a copy of the office's Notice of Privacy Practice.

Print Patient's Name if different from above _____

Signature of Patient or Legal Guardian _____

PLEASE LIST THE NAMES OF PEOPLE YOU AUTHORIZE US TO SPEAK TO ABOUT YOUR DENTAL CARE:

_____

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Office Use Only

As a privacy officer, I attempted to obtain the patient's (or representative's) signature of this acknowledgment document, but did not because:

_ It was an emergency
_ l could not communicate with the patient/responsible party
_ The patient refused to sign
_ The patient was unable to sign because _____

Other _____

3380 NE Sugarhill Ave, Jensen Beach, FL 34957
772-334-3653

Sugarhill Dental

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Melissa Kinsig D.M.D

APPOINTMENT POLICY

We respect our patient's time and make every effort to remain on schedule. Some visits, such as emergencies are not anticipated and could cause a delay. We will make every effort to notify you so you may choose to come later or re-schedule. If you are going to be late, we ask you notify us as soon as possible. If you are significantly delayed, your appointment may be modified we may need to reschedule your appointment.

CANCELLATION POLICY

We value each of our patients and because of the level of service we provide, your appointment is especially held just for you. We confirm each appointment 2 days in advance as a reminder. We ask that you make every effort to give us at least a 24-hour notice if you cannot make your scheduled appointment. When you give us 24-hour notice, your reserved appointment time can be available for another patient. In the event of a late notice cancellation or failed appointment there will be a $55.00 fee applied to your account.

INSURANCE POLICY

Our office is a participating provider with most dental PPO insurance companies. As a courtesy to you, we will file a claim for completed procedures for insurance we take on assignment. Your estimated out of pocket cost will be collected at the time of service.

Our responsibility is to provide you with the treatment that best meets your needs regardless of your insurance plan guidelines and limitations. We file your dental claims and do our very best to send all necessary information for payment. Any denied or unpaid claims will be the patient's responsibility. With the information provided to us by you and your insurance company, we are able to provide you with an estimate**.** Understand your insurance company makes the final determination for payment. In the event your insurance has not paid your claim within 60 days from the date of the procedure, you will be responsible for the balance.

We appreciate you understanding the value of our office policies and thank you in advance for your cooperation.

_____ _____

Signature of Patient or Responsible Party Date signed

Sugarhill Dental

Dr. Christopher W. Kindig
Dr. Melissa C. Kindig

Dental Insurance Information Disclaimer

Please **READ** carefully before signing and initial each section.

_____Our goal is to help you maximize your dental insurance benefits. Unfortunately, it is difficult to predict the limitations or restrictions your dental plan has in place. Many dental plans have waiting periods, frequency limitations and alternate benefits. It is important that when you receive a treatment plan from our office, you understand it is ESTIMATE **ONLY.**

_____I understand Sugarhill Dental has agreed to file my dental insurance as a courtesy and that I am fully responsible for any treatment costs which are denied or not covered by my insurance plan. I **understand that it is my responsibility to know the extent of my benefits, restrictions, and limitations.**

Signature_____Date_____