Kingston Family Dental

Patient Information:

First Name: _____ Last Name: _____

Address: _____ City: _____ State/Zip code: _____

Home Phone: _____ Work: _____ Cellular: _____

Sex: Female O Male O Marital Status: Single O Married O Divorced O Widowed O

Birth Date: _____ Age: _____ Soc.Sec.: _____ Drivers Lic: _____

I would like to receive correspondences via e-mail: Yes / No E-Mail: _____

Responsible Party (if someone other than patient):

First Name: _____ Last Name: _____

In case of emergency please contact: _____ Phone: _____

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

Pharmacy name & phone number: _____

_____

Please CIRCLE "Yes" or "No" to indicate if you have had ANY of the following:

Bad breath	YES / NO	Blisters on lips or mouth	YES / NO	Loose teeth or broken fillings	YES / NO
Bleeding gums	YES / NO	Burning sensation on tongue	YES / NO	Mouth pain, brushing	YES / NO
		Chew on one side of mouth	YES / NO	Orthodontic treatment	YES / NO
		Cigarette, pipe or cigar smoking	YES / NO	Pain around ear	YES / NO
		Clicking or popping jaw	YES / NO	Periodontal treatment	YES / NO
		Dry mouth	YES / NO	Sensitivity to cold	YES / NO
		Fingernail biting	YES / NO	Sensitivity to heat	YES / NO
		Food collecting between teeth	YES / NO	Sensitivity to sweets	YES / NO
		Grinding teeth	YES / NO	Sensitivity when biting	YES / NO
		Gums swollen or tender	YES / NO	Sores or growths in your mouth	YES / NO
		Jaw pain or tiredness	YES / NO	How often do you floss?	_____
		Lip or cheek biting	YES / NO	How often do you brush?	_____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: Self O Spouse O Child O Other O

Insured Soc.Sec. _____ Insured Birth Date: _____

Employer: _____ Ins.Company _____

Address: _____ Address: _____

City/ST/Zip: _____ City/ST/Zip: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Vera Matshkalyan, DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorizethe use of my signature on all insurance submissions. The above- named dentist may use my health care information and may disclose such information to the Above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Medical History...

Name of personal physician: _____

Address & phone #: _____ Approximate date of last visit: _____

Have you had any serious health problems in the last five years? ☐ Yes ☐ No; if yes, please explain:

_____

Are you currently pregnant? ☐ Yes ☐ No If yes, how many months? _____

Any prescription medications? ☐ Yes ☐ No Please list below medications, vitamins, and/or herbal supplements you take:

_____

_____

_____

Please check if you are allergic to any of the following:

- ☐ Local anesthetics
- ☐ Penicillin/other antibiotics
- ☐ Barbiturates, sedatives, sleeping pills
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Other _____
- ☐ Codeine/other narcotics
- ☐ Latex sensitivity

The following conditions **may require** a pre-medication with antibiotics. Please check if any of them apply to you or have in the past.

- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Open heart surgery: date: _____
- ☐ Transplant surgery: organ & date: _____
- ☐ You are undergoing treatment for cancer
- ☐ Mitral valve prolapse
- ☐ Prosthetic implant: Joint & date: _____
- ☐ Artificial valve
- ☐ Surgery with pins area & date: _____

You have taken the diet drug Fen Phen: date: _____

Please indicate if you have ever had or been treated for any of the following diseases or medical problems:

- ☐ Abnormal bleeding
- ☐ Abnormal blood pressure
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/ Seizures
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart problems
- ☐ Hepatitis A / B / C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease / Trouble
- ☐ Liver Disease / Trouble
- ☐ Low Blood Pressure
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet / Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, unexplained

List all surgery history: _____

_____

_____

The above health history, including all medications, allergies, and surgeries is total and complete.

Signature of Patient/Guardian/Responsible Party: _____ Date: _____

Kingston Family Dental

FINANCIAL POLICY & DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance we will help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services is due at the time of treatment. Our office offers the following options- Cash, Personal Check, Discover, Visa, MasterCard, and CareCredit Patient Financing.
***Checks not honored by your financial institution will be assessed a $25 service fee in addition to the financial institution fees.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
2. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We must emphasize that as a dental care provider, our relationship is with you, the patient, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility for the services rendered.

I understand that if I am unable to keep my appointment, I need to let Kingston Family Dental know at least 48 hours in advance. **I also understand Kingston Family Dental reserves the right to assess a minimum of $30 fee for late cancellations and/or missed appointments.**

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Patient Name (Print or Type) _____ Date _____

Signature of Patient or Responsible Party _____ Relationship (if responsible party) _____

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

I hereby give my permission to discuss **all** aspects of my dental treatment to the individuals listed below:
Name(s):_____
_____

Relationship to patient: ____Mother ____Father ____Husband ____ Wife

____ Other (Please Specify): _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)
