Patient Information

Name

SS#

First Name

Last Name

Address

Birthday

State

City

Zip Code

Sex

Male

Female

Home phone

Cell phone

Email

Marital Status

Patient or Parent/Guardian's Employer:

Spouse or Parent/Guardian's Name:

Spouse or Parent/Guardian's Employer

Emergency Contact

If student, name of school:

Emergency Phone

Work Address

State

City

Zip Code

How did you hear about our office?

Work Phone

Responsible Party

Responsible Party

Relationship to Patient

Same as patient (Skip to Insurance Information)

Responsible Address

Responsible Home phone

State

City

Zip Code

Responsible Cell phone

Responsible Email

Primary Dental Insurance

Name of Subscriber

Relationship to Patient

Susbcriber Birthday

Subscriber SS#

Subscriber Employer

Subscriber Employer Phone

Subscriber Employer Address

Primary Insurance Name:

State

City

Zip Code

Insurance Phone

Insurance Address

State

City

Zip Code

Insurance Group Number

Additional Information

Scheduling Needs or Preferences:

Any other information you would like us to know:

Patient History

Part of our approach to your dental care is understanding your total well-being. We appreciate you filling out the following form completely with the understanding that any and all information is kept strictly confidential.

Physician

Office Phone

Last Visit

Medications

Pharmacy

List medications you are currently taking:

Pharmacy Phone

Allergies

Aspirin Yes No

Barbiturates (Sleeping Pills) Yes No

Codeine	Yes	No	Erythromycin	Yes	No
Fluoride	Yes	No	Iodine	Yes	No
Latex	Yes	No	Local Anesthetic	Yes	No
Penicillin	Yes	No	Metal	Yes	No
Other Allergies			Sulfa	Yes	No

History

Do you use Controlled Substances?	Yes	No	Are you wearing contact lenses?	Yes	No
Do you use Tobacco?	Yes	No	Have you ever taken Fen-Phen/Redux?	Yes	No

Do you have any of the following?

High Blood Pressure	Yes	No	Heart Attack	Yes	No
Rheumatic Fever	Yes	No	Swollen Ankles	Yes	No
Fainting/Seizures	Yes	No	Asthma	Yes	No
Low Blood Pressure	Yes	No	Epilepsy/Convulsions	Yes	No
Leukemia	Yes	No	Diabetes	Yes	No
Kidney Diseases	Yes	No	AIDS or HIV	Yes	No
Thyroid Problem	Yes	No	Heart Disease	Yes	No
Heart Murmur	Yes	No	Cardiac Pacemaker	Yes	No
Angina	Yes	No	Frequently Tired	Yes	No
Anemia	Yes	No	Emphysema	Yes	No
Cancer	Yes	No	Arthritis	Yes	No
Joint Replacement or Implant	Yes	No	Hepatitis/Jaundice	Yes	No
Sexually Transmitted Disease	Yes	No	Stomach Troubles/Ulcers	Yes	No
Chest Pains	Yes	No	Easily Winded	Yes	No
Stroke	Yes	No	Hay Fever/Allergies	Yes	No
Tuberculosis	Yes	No	Glaucoma	Yes	No
Recent Weight Loss	Yes	No	Liver Disease	Yes	No
Heart Trouble	Yes	No	Respiratory Problems	Yes	No
Mitral Valve Prolapse	Yes	No	Cough or Throat Pain	Yes	No
Other Disease					

Women Only

Are you nursing?	Yes	No	Are you pregnant or think you	Yes	No

			may be pregnant?		
Are you taking oral contraceptives?	Yes	No			

Dental History

Reason for today's visit:

Name of Previous Dentist:

Previous Dentist Phone:

Date of last dental exam:

Date of last dental Xrays:

Have you ever experienced any of the following?

Do you have any sores or lumps in or near your mouth?	Yes	No	Are your teeth sensitive to hot/cold?	Yes	No
Have you had any neck or head injuries?	Yes	No	Do your gums bleed while brushing or flossing?	Yes	No
Do you feel pain to any of your teeth?	Yes	No	Are your teeth sensitive to sweet/sour?	Yes	No
Clicking	Yes	No	Pain (joint, ear, side of face)	Yes	No
Difficulty in opening or closing	Yes	No	Difficulty Chewing	Yes	No
Do you clench or grind your teeth?	Yes	No	Do you have frequent headaches?	Yes	No
Have you ever had any difficult extractions in the past?	Yes	No	Do you bite your lips or cheeks frequently?	Yes	No
Have you had any orthodontic treatments?	Yes	No	Have you ever had any prolonged bleeding following extractions?	Yes	No
Do you wear dentures or partials?	Yes	No	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Yes	No
Do you like your smile?	Yes	No			

Authorization & Release

Contract to Pay for Medical Services

In consideration of the required professional services provided to the above patient, I/we agree to pay the account for these services in full, at the time of service, unless other arrangements have been made with Dr. Kreger. I/we authorize Dr. Kreger to receive assignment of insurance payments. Any charges in excess of the benefits allowed under the responsible party's insurance plan, I/we understand that I/we are responsible to pay the difference. A finance charge of 1.5% monthly (18% APR) will be added to my outstanding account balance after 30 days.

Authorization to Release Information

Dr. Kreger is hereby authorized to release any medical or incidental information that may be necessary for medical care, or in processing insurance.

Legal Responsible Party

If the patient is a minor and/or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient.

By typing in your name, you are agreeing to this financial policy:

Full Name *

Date *

Financial Policy

How we handle insurance claims

We will make every attempt to verify eligibility and co-payment amounts prior to your appointment. After treatment we will bill your insurance carrier for their portion of the bill. We will be prompt in handling any requests for information to facilitate the claim. Even though you may have an insurance claim pending, you will receive a statement each month for the outstanding balance on your account.

You are responsible for paying your bill

Your insurance coverage is a contract between you and your company. Our office is not involved in setting your coverage limits, exclusions to your contract, or waiting periods. That means it's primarily your responsibility to see that your insurance company covers your bill.

We ask that you pay by cash, check, or credit card at the time services are rendered

While your insurance company may reimburse a portion of the cost of the dental care, we ask that you pay the deductible (co-payment) or payment in full (if there is no insurance coverage) prior to treatment. We understand some individuals need to make financial arrangements. Please talk with our business administrator prior to your appointment to find out what options are available.

We invite you to discuss our fees or financial policies with us

We are always happy to answer any questions about costs, insurance claims, billing questions, or financial plans.

AGREEMENT TO PAY

I request and authorize Karla M. Kreger, D.D.S. to provide me with dental services. I understand that I am personally responsible for the charges for the services I receive.

I agree to make full payment for services I receive unless prior arrangements have been made in writing. I agree to pay all reasonable attorney fees and costs of collections incurred by Dr. Kreger if my account is not paid as agreed. I also agree to pay interest on my unpaid balance at the rate of 18% per annum commencing 30 days after the date of service.

As a patient (or guardian of a patient) I understand that this office does not acknowledge agreement between parents accepting or denying financial responsibility for services provided. We consider the guardian (custodial) parent to be responsible for payment of services received.
I hereby authorize Karla M. Kreger, D.D.S. at its discretion, to bill my insurance carrier and any other persons or parties who may be liable for payment of these services. I also authorize my insurance carrier to make payment directly to Dr. Kreger.

If additional arrangements for payment are necessary, we will be happy to discuss these arrangements after you meet with the doctor to discuss your treatment needs.

By typing in your name, you are agreeing to this financial policy:

Full Name *

Date *

Notice of Privacy Practices

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Dr. Karla Kreger. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By typing in your name, you are agreeing to this Acknowledgment of the Notice of Privacy Practices:

Signature *

Date *

report abuse