KEMMET DENTAL DESIGN

1015 S Broadway Suite 42

## Patient Information

Today's Date_____ How did you hear about us?_____

Patient Name_____Preferred Name_____

(First) (Last) (MI)

Address_____City_____State_____Zip_____

Phone Number _____ _____ _____

(Home) (Cell) (Work)

Email Address_____SSN_____

May we contact you though Email and/or Text Messages to remind you of future appointments? Y/N

Birth Date_____ Gender: M/F Marital Status_____

Spouses Name_____

## Dental Information

Reason for today's Visit_____

Do you have any questions or concerns for Dr. Kemmet?_____

How would you rate you Smile? (Circle one) Excellent Good Fair Poor Isn't a Concern for me

How often do you Brush?_____ Do you Floss? Y/N How often?_____

X_____Date_____

(Signature of Patient or Guardian if Minor)


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## Dental Insurance

Policy Holder_____Relationship to Patient_____

Employer_____

Insurance Company_____SSN and DOB of Policy Holder_____

Insurance Company Address _____

(Address) (City) (State) (Zip)

Insurance Phone Number_____ID#_____Group #_____

I authorize Kemmet Dental Design to release information as needed to my insurance company including diagnosis, records of treatment provided or any examination received. I authorize my insurance company to pay out my dental benefits directly to Kemmet Dental Design. I understand that my dental insurance is a contract between me insurance company and that a laps in insurance coverage will result in full payment of dental services rendered. I understand that my insurance benefits may pay less than the actual bill for services, and I acknowledge that I am responsible for the remaining balance due for myself and or my dependants.

## Financial Agreements

As a courtesy my insurance will be billed by Kemmet Dental Design on my behalf, and after my insurance company has made a payment to Kemmet Dental Design I am responsible for the remaining amount. If I do not currently have dental insurance benefits, I agree to pay the full amount due for ALL completed services the day of my appointment, unless previous arrangements have been made with the office manager or other office staff. I understand that I will be responsible for all court costs, collection fees, and attorney fees in the event of non-payment.

Kemmet Dental Design values you as a patient and as such we reserve your appointment/s in advance. We ask that you give a 48 hour notice for any appointment that you are unable to keep. A $25.00 fee may applied to your account for either a NO SHOW appointment, or failure to cancel an appointment within 48 hours of the scheduled appointment time .Further more if you If you exhibit a pattern of consistency such as two failed appointments in 6 months, you may be dismissed as a patient in our practice.

X_____Date_____

(Signature of Patient or Guardian if Minor)

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## General Dentistry Informed Consent

1. **Examination and X-rays:** I understand that my initial visit may require radiographs in order to complete my examination, diagnosis and treatment plan.
2. **Changes in Treatment Plan**: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on my teeth, that were not discovered during my examination, the most common being root canal therapy following routine procedures. I give my permission to Dr. Kemmet to make any changes or additions necessary.
3. **Temporomandibular Joint Dysfunctions (TMJ):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower subsequent to routine dental treatment wherein the mouth is held in an open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist, and the cost of which is my responsibility.
4. **Fillings:** I understand that care must be exercised in chewing n my filling during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of a newly placed filling
5. **Removal of Teeth:** An Alternative to removal has been explained to me(root canal therapy, crowns, periodontal treatment, ect.) and I authorize Dr. Kemmet to remove the following teeth and any others necessary for the reasons in paragraph 2. I understand that removing teeth does not always remove all infection present and it may be necessary to receive further treatment. I understand the risks involved in having teeth removed, some of which are, pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time, or fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
6. **Crowns, Bridges, Veneers, and Bonding:** I understand that sometimes it is not possible to have an exact match for the color of my natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns, which my come off easily and that I must be careful to ensure that they are kept on until the permanent crowns can be delivered. I realize that the final opportunity to make final changes in my crowns, bridges or cap(including shape, fit and color) will be done before cementation. I understand that in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures affect my tooth surfaces and may require modification of daily cleaning procedures.
7. **Dentures Complete or Partial:** I realize that the full or partial dentures are artificial, constructed of plastic, metal and or porcelain. the problems of wearing those appliances have been explained to me including, looseness, soreness and the possibility of breakage. I realize that the final opportunity to make changes in my denture (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

8. **Endodontic Treatment( Root Canal):** I realize there is no guarantee that Root Canal Therapy will save my tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extended through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal therapy (apoicoetomy).
9. **Periodontal Treatment:** I understand that I have a serious condition causing gum inflammation and/or bone loss and that can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products, and follow other recommendations.

**Consent:** *I understand that dentistry is not an exact science, therefore: reputable parishioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist other than the treating dentists responsible for my dental treatment.*

X_____Date_____

(Signature of Patient or Responsible Party)

## Notice of Privacy of Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights as a privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may involved in treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information is available for me to read. I understand that Kemmet Dental Design has the right to change its Notice of Privacy of Practices from time to time and that I may contact Kemmet Dental Design at any time at the above address to obtain a copy of a current Notice of Privacy Practices.

I understand that I may request in writing that you restrict how private my information is used or disclosed to carry out treatment, health operations or payment. I also understand that you are not required to agree to these requested restrictions, but if you do agree then you are bound to abide by such restrictions.

X_____Date_____

(Signature of Patient or Responsible Party)

# MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | |
|---|---|---|---|
| AIDS/HIV Positive ◯ Yes ◯ No | Cortisone Medicine ◯ Yes ◯ No | Hemophilia ◯ Yes ◯ No | Radiation Treatments ◯ Yes ◯ No |
| Alzheimer's Disease ◯ Yes ◯ No | Diabetes ◯ Yes ◯ No | Hepatitis A ◯ Yes ◯ No | Recent Weight Loss ◯ Yes ◯ No |
| Anaphylaxis ◯ Yes ◯ No | Drug Addiction ◯ Yes ◯ No | Hepatitis B or C ◯ Yes ◯ No | Renal Dialysis ◯ Yes ◯ No |
| Anemia ◯ Yes ◯ No | Easily Winded ◯ Yes ◯ No | Herpes ◯ Yes ◯ No | Rheumatic Fever ◯ Yes ◯ No |
| Angina ◯ Yes ◯ No | Emphysema ◯ Yes ◯ No | High Blood Pressure ◯ Yes ◯ No | Rheumatism ◯ Yes ◯ No |
| Arthritis/Gout ◯ Yes ◯ No | Epilepsy or Seizures ◯ Yes ◯ No | High Cholesterol ◯ Yes ◯ No | Scarlet Fever ◯ Yes ◯ No |
| Artificial Heart Valve ◯ Yes ◯ No | Excessive Bleeding ◯ Yes ◯ No | Hives or Rash ◯ Yes ◯ No | Shingles ◯ Yes ◯ No |
| Artificial Joint ◯ Yes ◯ No | Excessive Thirst ◯ Yes ◯ No | Hypoglycemia ◯ Yes ◯ No | Sickle Cell Disease ◯ Yes ◯ No |
| Asthma ◯ Yes ◯ No | Fainting Spells/Dizziness ◯ Yes ◯ No | Irregular Heartbeat ◯ Yes ◯ No | Sinus Trouble ◯ Yes ◯ No |
| Blood Disease ◯ Yes ◯ No | Frequent Cough ◯ Yes ◯ No | Kidney Problems ◯ Yes ◯ No | Spina Bifida ◯ Yes ◯ No |
| Blood Transfusion ◯ Yes ◯ No | Frequent Diarrhea ◯ Yes ◯ No | Leukemia ◯ Yes ◯ No | Stomach/Intestinal Disease ◯ Yes ◯ No |
| Breathing Problem ◯ Yes ◯ No | Frequent Headaches ◯ Yes ◯ No | Liver Disease ◯ Yes ◯ No | Stroke ◯ Yes ◯ No |
| Bruise Easily ◯ Yes ◯ No | Genital Herpes ◯ Yes ◯ No | Low Blood Pressure ◯ Yes ◯ No | Swelling of Limbs ◯ Yes ◯ No |
| Cancer ◯ Yes ◯ No | Glaucoma ◯ Yes ◯ No | Lung Disease ◯ Yes ◯ No | Thyroid Disease ◯ Yes ◯ No |
| Chemotherapy ◯ Yes ◯ No | Hay Fever ◯ Yes ◯ No | Mitral Valve Prolapse ◯ Yes ◯ No | Tonsillitis ◯ Yes ◯ No |
| Chest Pains ◯ Yes ◯ No | Heart Attack/Failure ◯ Yes ◯ No | Osteoporosis ◯ Yes ◯ No | Tuberculosis ◯ Yes ◯ No |
| Cold Sores/Fever Blisters ◯ Yes ◯ No | Heart Murmur ◯ Yes ◯ No | Pain in Jaw Joints ◯ Yes ◯ No | Tumors or Growths ◯ Yes ◯ No |
| Congenital Heart Disorder ◯ Yes ◯ No | Heart Pacemaker ◯ Yes ◯ No | Parathyroid Disease ◯ Yes ◯ No | Ulcers ◯ Yes ◯ No |
| Convulsions ◯ Yes ◯ No | Heart Trouble/Disease ◯ Yes ◯ No | Psychiatric Care ◯ Yes ◯ No | Venereal Disease ◯ Yes ◯ No |
| | | | Yellow Jaundice ◯ Yes ◯ No |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____