Patient Name:____

DENTAL HISTORY

Last dental cleaning: ______________________
Former dentist: __________________________ City/State: ___________

Indicate if you have, or have had, any of the following:

Y ☐ N ☐ Bad breath/sour taste in mouth
Y ☐ N ☐ Burning sensations in mouth
Y ☐ N ☐ Dry mouth
Y ☐ N ☐ Grinding of teeth
Y ☐ N ☐ Headaches/migranes
Y ☐ N ☐ Sensitivity to hot and cold
Y ☐ N ☐ Soreness in jaw
Y ☐ N ☐ Bleeding gums
Y ☐ N ☐ Clicking or popping in jaw
Y ☐ N ☐ Food catching between teeth
Y ☐ N ☐ Hard to open mouth wide
Y ☐ N ☐ Pain/soreness around ears or eyes
Y ☐ N ☐ Snoring
Y ☐ N ☐ Stiff neck muscles

Indicate what is important to you when making decisions regarding your dental health:

Y ☐ N ☐ Appearance/Aesthetics
Y ☐ N ☐ Fear or anxiety
Y ☐ N ☐ Health
Y ☐ N ☐ Remove silver fillings
Y ☐ N ☐ Replace missing teeth
Y ☐ N ☐ Straighter teeth
Y ☐ N ☐ Comfort
Y ☐ N ☐ Finances
Y ☐ N ☐ Insurance coverage
Y ☐ N ☐ Repair chipped teeth
Y ☐ N ☐ Replace old crowns
Y ☐ N ☐ Whiter teeth

AUTHORIZATION AND ACKNOWLEDGMENT:

- I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered.
- I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I certify that I have read and understand the above health history. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his or her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient or legal guardian signature: ______________________________ Date:___________

KENDRICK
dental group

Name:____ Date:________________________

HEALTH HISTORY

Indicate if you have, or have had, any of the following:

Y ☐ N ☐ AIDS/HIV
Y ☐ N ☐ Arthritis
Y ☐ N ☐ Asthma
Y ☐ N ☐ Chemical dependency
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Fainting or dizziness
Y ☐ N ☐ Heart murmur
Y ☐ N ☐ Herpes
Y ☐ N ☐ Joint replacement/implants
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Pacemaker
Y ☐ N ☐ Respiratory problems
Y ☐ N ☐ Sinus trouble
Y ☐ N ☐ Swollen neck glands
Y ☐ N ☐ Thyroid problems
Y ☐ N ☐ Other
____

Y ☐ N ☐ Autism Spectrum disorder
Y ☐ N ☐ Anemia or blood disorder
Y ☐ N ☐ Artificial heart valves
Y ☐ N ☐ Cancer
Y ☐ N ☐ Circulatory condition
Y ☐ N ☐ Epilepsy or seizures
Y ☐ N ☐ Hepatitis type _____
Y ☐ N ☐ High blood pressure
Y ☐ N ☐ Low blood pressure
Y ☐ N ☐ Mitral valve prolapse
Y ☐ N ☐ Psychiatric care
Y ☐ N ☐ Rheumatic fever
Y ☐ N ☐ Stroke
Y ☐ N ☐ Stomach ulcer/hyperacidity
Y ☐ N ☐ Tobacco use
Y ☐ N ☐ Tuberculosis
Y ☐ N ☐ Are you currently pregnant?

Have you had any serious illness, operation, or been hospitalized in the past 5 years? Y ☐ N ☐
If yes, what was the problem? ____

Do you have any disease or problem not listed above that we should be aware of? Y ☐ N ☐
If yes, please explain: ____

Physician's name:______________________________ Date of last visit: ______________________________

IN CASE OF EMERGENCY, PLEASE CONTACT:
Name: ______________________________________ Phone number: (____) ______________________________

Please list any medications you are currently taking. Please include non-prescription medications:

______________________________ ______________________________ ______________________________

Please list any known allergies:____ or ☐ NONE KNOWN

Patient signature: ____ Date: ______________

Financial Policy

Patient Name ____

Payment in full is expected when services are rendered. All other arrangements must be made prior to your appointment.

Insured Patients

- Although your insurance may assist you with partial payment of your treatment, the estimated portion that is not covered is due when services are rendered.
- As a courtesy to our patients, we will file your primary insurance for you. If your insurance has not paid within 60 days, you will be responsible for the entire unpaid balance; payment in full will be expected at this time. We will however, continue to work with you and your insurance company to expedite your reimbursement.

We do not file Medical Insurance

Payment may be made by any of the following methods.

CASH CHECK CREDIT CARD CARE CREDIT

- I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claim(s) by my insurance company.
- I agree to pay any and all unpaid balance on my account.
- I authorize all insurance benefits paid directly to KENDRICK DENTAL GROUP.
- If payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the benefits check to KENDRICK DENTAL GROUP or make payment immediately to KENDRICK DENTAL GROUP.
- I authorize the release of information to my insurance company, attorney, or legal representative to obtain reimbursement of any claim(s) or for other reasons.
- A finance charge of 1.5% will begin to accrue after 90 days from the date of service on the unpaid balance of my account even though insurance may be pending.
- A fee of $30.00 will be incurred for each returned check.
- I understand and agree that if the amounts for which I am responsible become delinquent, I will pay for all costs associated with the collection process. This includes but would not be limited to collections fees, attorney fees, and court cost.
- I authorize the office to discuss my account with a spouse, parent, step parent, subscriber, of any insurance that is requested to be filed on my behalf, or responsible party no matter if I am considered legally to be an adult.

____ ____________________

Signature of Responsible Party Date