Kerr Family Dental

Derek Kerr DDS

Welcome to our office. We look forward to working with you in maintaining your dental health.

Our goal is to help you preserve your natural teeth for your lifetime.

Patient Information (Please fill in all blanks)

Name: _____ M/F Birthdate: _____ SSN#_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone#_____ Work Phone #_____ Cell Phone#_____

Email: _____ Consent to receive email appointment reminders. Y / N

Marital Status: M S D W

Guarantor Information (If the patient is under 18 years of age)

Person responsible for this account: _____Relationship to patient: _____

DOB: _____ SSN# _____ Contact Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance

Insurance Company: _____

Address: _____

Phone Number: _____

Plan Holder: _____

Plan Holder SSN: _____DOB:_____

Relationship to patient: _____

Plan holder address (if different from patient):_____

_____

Plan Holder Employer: _____

Employer Phone Number: _____

Secondary Insurance

Insurance Company: _____

Address: _____

Phone Number: _____

Plan Holder: _____

Plan Holder SSN: _____DOB:_____

Relationship to patient: _____

Plan holder address (if different from patient): _____

_____

Plan Holder Employer:_____

Employer Phone Number:_____

Please Select the Appropriate Answer

Are you having any pain or discomfort at this time? Yes No Explain_____

Do you feel nervous about having dental treatment? Yes No

Is there anything you dislike about your smile? Yes No

Have you been under the care of a medical doctor in the past two years? Yes No

Have you had any excessive bleeding requiring special treatment? Yes No

Are you taking any vitamins/herbal supplements/holistic remedies? Yes No

Do you smoke or use tobacco products? Yes No

Allergies-Select all that apply:

_Aspirin Allergy _Codeine Allergy _Erythromycin Allergy _Hay Fever _Latex Allergy _Penicillin Allergy

_Sulfa Allergy _OtherAllergies_____

Medical Conditions-Please select all that apply:

_Anemia	_Arthritis	_Artificial Joints	_Asthma
_Blood Disease	_Cancer	_Diabetes	_Dizzy Spells or Fainting
_Epilepsy or Seizures	_Excessive Bleeding	_Glaucoma	_Head Injury
_Heart Condition	_Heart Disease	_Heart Murmur	_Heart Pacemaker
_Hemophilia	_Hepatitis A	_Hepatitis B	_ Hepatitis C or other
_Herpes	_High Blood Pressure	_HIV+/AIDS	_Jaundice
_Kidney Disease/Trouble	_Liver Disease	_Low Blood Pressure	_Mental Disorder
_Nervous Disorder	_Osteoporosis	_Pregnant or Nursing	_Radiation Therapy
_Respiratory Problems	_Rheumatic Fever	_Rheumatism	_Sexually Trans. Disease
_Sinus Trouble	_Stomach Problems	_Stroke	_Tuberculosis (TB)
_Tumors	_Ulcers		

Other Condition: _____

Medications-Please List any medications you are currently taking or provide medication list:

_____

_____

Authorization

Payment or Copay is expected the day that services are rendered to the patient.

To the best of my knowledge, the questions on these forms 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 my medical status.

I authorize the insurance company indicated on these forms to pay 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 the insurance company. Copay is due on the day of service.

I understand there is a missed appointment policy. I am responsible for the fee of **$40.00** for any missed or canceled appointment with less than 24 hours' notice.

Signature of Patient, Parent or Guardian: _____ **Date**: _____

Notice of Privacy Practices Acknowledgment Receipt

I have received the Office's Notice of Privacy Practices on this visit or the previous one. I understand I can request another copy at any time.

I give authorization to this office to release any and all health record information and results to the persons listed below.

Name_____ Relationship_____ Phone Number_____

Name_____ Relationship_____ Phone Number_____

Name_____ Relationship_____ Phone Number_____

Signature of Patient, Parent or Guardian: _____ **Date**: _____

Patient Record of Disclosures

In General, The HIPAA Privacy rules gives individuals the right to request restrictions on disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI may be made by alternative means such as: Sending correspondence to the Individual's Office or Cell Phone, in addition to or instead of the individual's Home Phone.

Please check all that apply

Home Phone #_____

Leave message with detailed information __Yes __No

Leave call back number only __Yes __No

Work Phone#_____

Leave message with detailed information __Yes __No

Leave call back number only __Yes __No

Cell Phone Number#_____

Leave message with detailed information __Yes __No

Leave call back number only __Yes __No

Consent to receive text message reminders __Yes __No

Cell Phone Carrier:_____

Signature of Patient, Parent or Guardian: _____ **Date**: _____