

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# \_\_\_\_\_ Cell Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_

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# \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Insurance Information**

**Primary Insurance**

Insurance Company: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

Member ID# \_\_\_\_\_ Policy# \_\_\_\_\_ Plan Holder Employer: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ SSN# \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber address (if different from patient): \_\_\_\_\_

**Secondary Insurance**

Insurance Company: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

Member ID# \_\_\_\_\_ Policy# \_\_\_\_\_ Plan Holder Employer: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ SSN# \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber address (if different from patient): \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**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 now or have you ever used a bisphosphonate? 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:**

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

Other Condition: \_\_\_\_\_

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

---

---

---

---

---

**Please check all that apply**

**Home Phone#** \_\_\_\_\_ Leave message \_\_Yes \_\_No

**Cell Phone#** \_\_\_\_\_ Leave message \_\_Yes \_\_No      Consent to receive text messages \_\_Yes \_\_No

**Work Phone#** \_\_\_\_\_ Leave message \_\_Yes \_\_No

**Email:** \_\_\_\_\_ Consent to receive emails. \_\_Yes \_\_No

**Pharmacy Name & Location** \_\_\_\_\_

**Authorizations**

**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.

**Patient has given consent to retrieve medication history from Pharmacy and Physicians.**

Disclaimer: Certain information may not be available or accurate in this report, including items that the patient asked not be disclosed due to patient privacy concerns, over-the-counter medications, low-cost prescriptions, prescriptions paid for by the patient or non-participating sources, or errors in insurance claims information. The provider should independently verify medication history with the patient.

**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 \_\_\_\_\_

**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 Cell Phone, in addition to or instead of the individual's Home Phone.

**Signature of Patient, Parent or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_