Patient Registration and Health Information Questionnaire

(Ages 18 and Older)

Welcome to Kinsler Family Dentistry! Our office adheres to written policies and procedures to protect your privacy. This information is for our records only and will be kept confidential subject to applicable laws. Please note that you may be asked additional questions regarding your responses to this questionnaire and there may be additional questions concerning your health history. This information allows us to provide the best possible care for you during your visit.

Patient Information:

Patient Name: _____ Date of Birth: _____ Sex: ___ M ___ F
First Last Middle

Address: _____ SSN: _____
Street Address City State Zip Code

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____ Work Phone: ( ) _____-_____ E-mail: _____

Marital Status (Circle One): Single Married Widowed Divorced Patient Employed by: _____

Spouse/Parent Name:_____ Spouse/Parent Employed by: _____

Emergency Contact: _____ Relationship: _____ Phone Number: ( ) ____-_____

Whom may we thank for referring you to our office? _____

Insurance Information:

Primary Dental Insurance:

Insured Name: _____ Insured Date of Birth: _____ Insured SSN: _____

Secondary Dental Insurance:

Insured Name: _____ Insured Date of Birth: _____ Insured SSN: _____

I authorize the disclosure of my records (or my child's records) to Kinsler Family Dentistry. This authorization will remain in effect until I revoke it in writing. I authorize payment directly to Kinsler Family Dentistry of the insurance benefits otherwise payable to me. I understand and agree that I am responsible for payment of all services including any co-insurance (co-payments), deductible or services not covered by my insurance.

Patient or Responsible Party Signature: _____ Date: _____

Dental History

What is the reason for your dental visit today? What dental concerns do you have?

_____

_____

Approximate date of your last dental exam: _____ Where? _____

Please mark your responses with an (X)

DENTAL CONDITIONS	Yes	No	?	DENTAL CONDITIONS	Yes	No	?
Have you ever had a serious injury to your head or mouth?				Do you wear dentures or partial dentures?			
Do you have any sores or ulcers in your mouth?				Do you grind or clench your teeth?			
Does food or floss easily get caught between your teeth?				Is you experience feelings of dry mouth frequently?			
Are your teeth sensitive to cold, hot or sweets?				Are your teeth generally sensitive to temperatures?			
Have you been instructed to take antibiotics before dental treatment?				Have you ever had treatment for gum disease?			
Are you currently experiencing dental pain or discomfort?				Have you had your wisdom teeth removed?			
Do you have any jaw popping or jaw joint pain?				Do your gums bleed when you brush or floss?			
Does dental treatment make you extremely nervous or frightened?				Other:			

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Medical History

Are you under the care of a physician? ___ Yes ___ No

If yes, what condition(s) are being treated? _____

Physician's Name: _____ Phone Number: ( ) _____-_____
First Last Middle

Address: _____
Street Address City State Zip

Have you had a serious illness, operation or been hospitalized in the past 5 years? ___ Yes ___ No

If yes, what was the problem or illness? _____

Preferred Pharmacy: _____
Name Location

MEDICAL CONDITIONS **Please mark an (X) for your responses**	**Yes**	**No**	**?**
Have you had an orthopedic total joint (hip, knee, elbow, or finger) replacement? * Date:			
Are you taking or scheduled to begin taking alendronate (**Fosamax®**) or risedronate (**Actonel®**) for osteoporosis?			
Were you treated or are you scheduled to be treated with **Aredia®** or **Zometa®** for skeletal complications of cancer?			
Do you use tobacco? If yes, please circle: Cigarettes, cigars, pipe, snuff, vape and/or chew.			
Do you drink alcoholic beverages? If yes, how much in last 24 hours? In a typical week?			
Artificial (prosthetic) Heart Valve?*			
Previous Infective Endocarditis?*			
Damaged valves in a transplanted heart?*			
Unrepaired or Repaired Cyanotic Congenital Heart Disease?*			

Antibiotics prior to your dental treatment may be necessary for the above conditions marked with an asterisk symbol

WOMEN ONLY **Please mark an (X) for your responses**	**Yes**	**No**	**?**
Are you pregnant? If yes, number of weeks:			
Nursing?			

ALLERGIC TO OR ADVERSE REACTION?	**Yes**	**No**	**DK**	**ALLERGIC TO OR ADVERSE REACTION?**	**Yes**	**No**	**?**
Aspirin?				Latex?			
Penicillin, Amoxicillin or Augmentin®?				Metals?			
Other antibiotics? Please list:				Sedatives or sleeping pills?			
Sulfa Drugs?				Local Anesthetics?			
Codeine?				Others? Please list:			

MEDICAL CONDITION	**Yes**	**No**	**?**	**MEDICAL CONDITION**	**Yes**	**No**	**?**
Cardiovascular Disease?				HIV/AIDS?			
Angina or Chest Pains?				Eating Disorder?			
High Cholesterol?				Gastrointestinal Disease?			
Stroke?				IBS?			
Congestive Heart Failure?				Reflux, GERD, Ulcers?			
Damaged Heart Valve?				Hypothyroid/Low thyroid function?			
Heart attack?				Stroke?			
Heart Murmur?				Fainting Spells or Seizures?			
Low Blood Pressure or Hypotension?				Epilepsy?			
High Blood Pressure or Hypertension?				Sleep Apnea? Use a CPAP machine?			
Pacemaker?				Depression?			
Other congenital heart conditions?				Anxiety?			
Blood thinners (Plavix, Coumadin, Aspirin, Xarelto) ?				ADD or ADHD			
Kidney Disease?				Bipolar Disorder?			
Liver Disease?				Osteoporosis?			
Hepatitis?				Severe headaches/migraines?			
Arthritis? Rheumatoid or Psoriatic Arthritis? (Circle)				Chronic pain?			
Autoimmune Disease: Lupus? IBD? MS? Hashimoto's? Celiac? Psoriasis?				History of Cancer—treated with chemo or radiation?			
Asthma?				Gout			
Emphysema?				Sinus problems?			
COPD?				Seasonal allergies?			
Diabetes, Type I or II?				Any other disease, condition or problem?			

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I understand the importance of a truthful health history and that Dr. Kinsler and her staff will rely on this information for treating me. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Kinsler, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form. I authorize the diagnosis of my dental health by means of radiographs or other diagnostic aids deemed appropriate. I authorize Kinsler Family Dentistry to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners via paper or electronic transmission.

Patient or Responsible Party Signature: _____ ***Date:*** _____

Reviewed by Dr. Kinsler: _____ ***Date:*** _____

KINSLER
Family Dentistry

Current Medication List

Patient Name: _____

Date of Birth: ___/___/_____

Please include Non-prescription medicines and supplements
It helps if you bring your bottle with you to your appointments.

ALLERGIES? *(please list below)*

_____

Medicine/Supplement Name	Dosage? (mg, etc.)	What is this taken for?

Patient or Responsible Party Signature: _____ ***Date:*** _____

Reviewed by Dr. Kinsler: _____ ***Date:*** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I have been provided access to Kinsler Family Dentistry's Notice of Privacy Practices (available both online and in the office) and have had full opportunity to read and consider its terms. I understand that the Notice of Privacy Practices governs how Kinsler Family Dentistry may use and disclose my protected health information and how I can get access to my protected health information.

Patient or Responsible Party Initials (Please Print): _____

AUTHORIZATION TO RELEASE INFORMATION

Many patients allow family members such as their spouse, parents, or others to call and request information regarding treatment and/or financial information. Under the requirements for H.I.P.A.A., we are not allowed to provide this information to anyone without the patient's consent. If you wish to have your information released to anyone other than yourself, you must complete this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Kinsler Family Dentistry to release my own or my dependents information to the following individuals (if applicable):

****PARENT OR GUARDIAN INFORMATION SHOULD BE ENTERED IF PATIENT IS UNDER 18.***

Name (Please Print): _____ Relationship: _____ Phone #_____
Name (Please Print): _____ Relationship: _____ Phone #_____
Name (Please Print): _____ Relationship: _____ Phone #_____

Patient or Responsible Party Initials (Please Print): _____

CONSENT TO RECEIVE ELECTRONIC COMMUNICATIONS

Patient or Responsible Party Initials (Please Print): _____

(Initial Below)

I _____ DO AGREE

I _____ DO NOT AGREE

that Kinsler Family Dentistry may communicate with me electronically at the email address and/or mobile phone number listed below.

Mobile Phone Number: _____

Email Address: _____

I am aware that there is some level of risk in receiving any form of electronic communications. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

I can withdraw my consent to electronic communications at any time by contacting:
Kinsler Family Dentistry via phone (765) 659-2124 or email info@kinslerfamilydentistry.com.

By signing this document, I am acknowledging the Receipt of Notice of Privacy Practices, authorizing The Release of Information as instructed, and consenting to my election regarding Electronic Communications.

Patient or Responsible Party Name (Please Print): _____

Patient or Responsible Party Signature: _____ Date _____

FINANCIAL POLICY

Thank you for choosing Kinsler Family Dentistry for your dental care! Our entire team is dedicated to helping you achieve and maintain long-term dental health and a beautiful smile by making every effort to provide treatment plans that fit within your budget. We accept cash, personal checks, Visa, MasterCard, Discover, and American Express. We are also pleased to offer our patients the CareCredit® card, North America's leading patient payment program. CareCredit lets you begin your treatment immediately, then pay for it over time with low monthly payments that fit easily into your monthly budget. All financial arrangements must be completed prior to the procedure being completed.

Patients with Dental Insurance:

Kinsler Family Dentistry will file dental insurance claims as a courtesy to our patients. In order to benefit from this service, I agree to provide updated insurance information prior to each appointment or upon request. I understand that I am responsible for any applicable deductibles and/or estimated patient portions of fees at the time of service. I authorize payment for services rendered to be paid by any third party; including, but not limited to, insurance carriers directly to Kinsler Family Dentistry.

As the contractual obligation with the insurance company is between you and your insurance carrier, we do recommend you make yourself familiar with your insurance benefits prior to visiting the office. We will work hand in hand with you to maximize your insurance reimbursement for covered procedures, however Kinsler Family Dentistry is not responsible for how your insurance company handles claims or for what benefits are paid or unpaid on a claim. Our office can only assist you in **estimating** your portion of the cost of treatment. We at no time **guarantee** what your insurance will or will not do with each claim.

Patients without Dental Insurance:

Full payment is required at the time of service unless prior financial arrangements have been completed.

Delinquent Accounts and Fees:

Delinquent accounts will be required to pay all past due balances in full prior to receiving new treatment or incurring new charges for services or products. All future charges for services or products must be paid at the time services or products are rendered. A $5.00 re-billing fee may be applied to accounts exceeding 60 days past due. A $40.00 charge will be applied to all returned checks. I agree to reimburse Kinsler Family Dentistry for all costs and expenses including attorney's fees and court fees, incurred in our collections efforts. In the event of a suit, I agree the venue shall be in Clinton County, Indiana. I acknowledge that any demographic information provided by me, including home and mobile phone numbers, may be used to contact me for any purpose, including collections efforts.

Custody Agreements:

The parent/guardian that brings the dependent child to the dental visit will be the responsible party for paying all fees incurred on that date of service. If there are unpaid balances, this parent/guardian will be held solely responsible for any balances and/or fees related to that date of service. Kinsler Family Dentistry will not be responsible for or take any part in communicating with the other parent/guardian to resolve issues related to appointment scheduling or payment.

I hereby certify that I have read, understand, and agree to all content within the Financial Policy as stated above:

Patient or Responsible Party Name (Please Print): _____

Patient or Responsible Party Signature: _____ ***Date*** _____

CANCELLATION POLICY

Please understand that Kinsler Family Dentistry does not overbook our schedule to accommodate for patients that fail or miss their scheduled appointment(s). We reserve your appointment time specifically for you and realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, short notice cancellations and/or no-shows result in lost opportunities for our dental practice to operate at its most efficient level. This policy is in place out of respect for all of us, including you.

Late Arrival Policy:

Patients are asked to arrive at their appointments before their scheduled appointment time. A grace period of 10 minutes will be permitted for unforeseen delays a patient may encounter while traveling to the office for their scheduled appointment. If a patient arrives more than 10 minutes late for their appointment, the patient may be seen if the schedule permits, or will be rescheduled for a later date. This process will ensure patients who do arrive on time are seen in a timely manner.

No-Show/Cancellation Policy:

A failed appointment is an appointment that is cancelled or rescheduled without 24 hours' notice or an appointment where a patient does not show up at all. **A $40.00 fee may be applied for any failed appointments that occur within 24 hours of your scheduled appointment time.** This charge cannot be billed to insurance and must be paid on or before your next scheduled appointment.

Our team makes every possible effort to keep you informed of upcoming appointments through a robust appointment reminder and confirmation process:

1) If you schedule a follow-up appointment in our office, you will leave with an appointment card and/or a printed walkout statement that includes the time and date for your next appointment(s)
2) Patients receive appointment reminders via text/email 7 days prior to the scheduled appointment
3) Patients then receive appointment confirmation requests via text/email 2 days prior to their schedule appointment
4) If patients have not responded to the confirmation request, our office will then attempt to contact you via phone to confirm your upcoming appointment

It is the patient's responsibility to cancel or reschedule the appointment no less than 24 hours prior to their scheduled appointment. A pattern of failed appointments may result in a limitation to schedule same-day appointments only, up to and including dismissal from our practice.

NOTE: You will never be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time.

I hereby certify that I have read, understand, and agree to all content within the Cancellation/No-Show Policy as stated above:

Patient or Responsible Party Name (Please Print): _____

Patient or Responsible Party Signature: _____ Date: _____