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 ____________

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 ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ____________

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 ____________

K2 Dentistry
916 Loganville Highway, Suite 180
Bethlehem, GA 30620

Patient's Name:____ Gender: M F Date:_________
(First) (MI) (Last)

Patient's Birthdate: ____/____/_______ Social Security Number:______-____-_______Height_______ Weight_____

Single_______Married__________Separated_________Widowed__________Divorced_______

Home Address____
(Street) (City) (State) (Zip Code)

Home Telephone:_______________Work Telephone:________________Cell Phone:________________________

Patient's Occupation:____________________________ Patient's Employer:_________________________________

Business Address:____
(Street) (City) (State) (Zip Code)

Email Address:____

Spouse's Name: ____

Spouse's Birthdate: _________________________________ Social Security Number: _______-______-_______

Spouse's Occupation/Employer: ____

In Case of Emergency, please contact:__________________________________Telephone:__________________

Tell us how you were referred to our office:____

Reasons or concerns for today's visit:____

FEES

All fees are due at the time of service

Please indicate your method payment:

( ) Mastercard, Visa, Discover, American Express

(Account #_____________________ Expiration Date______

( ) Check or cash in full at time of visit

DENTAL COVERAGE

PRIMARY COVERAGE

Employer: ___________________________

Insurance Co.__________________________

Policy No.______________________________

Group Number:__________________________

Insurance Phone Number:________________
Coverage: Family ( ) Individual ( )

The information I have provided is complete and accurate to the best of my knowledge. I consent to whatever procedures are deemed necessary to diagnose my oral condition. I personally guarantee payment of all services rendered, whether I am utilizing insurance benefits or not.

Patient's Signature____**Today's Date**:___________________________

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916 Loganville Highway, Suite 180
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Phone (770) 868-0088
Fax (770) 868-0119

Cosmetic and General Dentistry

Please read and sign this statement before we agree to accept assignment directly from your insurance. This avoids any misunderstandings and facilitates the processing of your insurance claim. If you have any question, please ask us. Thank-you

I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance fails to make payment within 45 days, I will be responsible for the full amount owed to K2 Dentistry.

As a courtesy we will try to verify your benefits by phone and estimate the amount not paid by the insurance company. We cannot be responsible for the exact verbal verification; therefore, I understand and agree that I am responsible for the amount not paid by the insurance company. Insurance benefits are subject to change upon reviewing the claim.

I understand that after the insurance company pays K2 Dentistry, there could be still be balance remaining, for which I am responsible.

I understand and agree that if upon payment by the insurance company, there is a remaining balance; I am responsible for the amount in full at that time.

____________________________ __________________

Responsible Party Signature **Date of Signature**

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OUR TIME SPENT TOGETHER IS VALUABLE

Our office loves to provide personalized attention to our patients. It is nice to visit in a friendly, relaxed atmosphere while providing cosmetically attractive, high quality care. We need your help in order to maintain this tradition.

Most of all, what we ask in return is that you arrive on time for scheduled appointment time so that all treatment can be completed. In order to provide individualized attention to all or our patients, additional visits, and /or rescheduling may be necessary to complete your treatment if you are unavoidably late.

We ask that your honor your commitment to your appointment time. In order to avoid being charged $50.00 for a missed appointment, we request 48 business hours as notice of any scheduling change. This is necessary to hold down the costs of dental care for everyone. Each of our patient's time is valuable.

Sign: ______________________________ Date: _________________

Lets work together to find appointment times that work best for you!

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E-Mail Permission

I, _______________________________________ give my permission to the office of K2 Dentistry to contact me by email:

*E-mail:__________________________________

This personal information is totally confidential and will not be disseminated to any outside party for any other purpose. Its use will be limited to the communication with our patients concerning their scheduling, inquiries, and alerts directly related to their oral health.

Signature___________________________

Date_____________________________

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NOTICE OF PRIVACY PRACTICE

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this notice to each patient no later than the date of our first service delivery to the patient, including services delivered electronically to the patient, after April 14. We must make a good faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them.

I hereby acknowledge that I have received a written copy of the HIPAA Privacy Practice.

______________________________________ __________
Patient Signature Date