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KENNEDY DENTAL

Dr. Jamar Anderson
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PATIENT REGISTRATION FORM

First Name: _____ Last Name: _____ Middle Initial: ____
Preferred Name: _____ Date of Birth: _____ Gender: _____
Address: _____
City/State/Zip: _____
Cell Phone: _____ E-mail Address: _____
Social Security Number: _____ Employer: _____

Emergency Contact Name: _____ Relationship: _____
Emergency Contact Number: _____

Communication Preferences for Appointment Reminders, Treatment Updates, etc. (check all that apply):

- Text message
- Phone call (including leaving a message/voicemail)
- E-mail

You may discuss my treatment with (check all that apply):

- Spouse/Common-law-partner: _____
- Children: _____
- Parents: _____
- Other: _____

INSURANCE INFORMATION

Fill out of applicable. Please bring your insurance card with you if you have one. We are only able to file with two insurances.

Primary

Name of Insured: _____
Date of Birth of Insured: _____ Employer: _____
Relation: _____ Social Security Number of Insured: _____
Insurance Company: _____ Plan Name: _____
Group Number: _____ ID Number: _____

INSURANCE INFORMATION (cont)

Secondary (If applicable)

Name of Insured: _____

Date of Birth of Insured: _____ Employer: _____

Relation: _____ Social Security Number of Insured: _____

Insurance Company: _____ Plan Name: _____

Group Number: _____ ID Number: _____

NOTICE OF PRIVACY PRACTICES

By signing this form, I give Kennedy Dental my consent to disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for other similar healthcare operations.
I have been informed that I may review the practice's Privacy Policies (available on our website or paper copy located at the front desk) for a more complete description of uses and disclosures prior to signing this document and any time thereafter.
I understand that Kennedy Dental has the right to change their privacy practices and that I may obtain any revised notices at the practice.
I understand that I have the right to request restriction of how my processed health information is used. However, I also understand that Kennedy Dental is not required to agree to the request. If Kennedy Dental agrees, they must follow the restriction.
I understand that I may revoke consent at any time by making a request in writing, except for information already used or disclosed.

FINANCIAL POLICY

I understand and acknowledge that:

- **Full payment for my treatment is due at the time of service, unless by prior arrangement.**
- My dental team is providing me with **ESTIMATES** as to what my cost will be, however, **this is not a guarantee**. Sometimes, unforeseen circumstances arise that change the nature of treatment. In these circumstances, the cost of treatment will change.
- **If I have dental insurance, I further understand and acknowledge the following:**
    - As a courtesy, **my dental office will submit claims to my insurance company on my behalf**. If my insurance company has not made payment within 60 days, I will be asked to contact them myself to make sure payment is expected. I understand if payment is not received or denied I will be responsible for paying the full amount at that time. I understand balances not paid in full within 90 days of the treatment date will receive a service charge and be sent to a collections agency.
    - **I am responsible for payment regardless of any insurance company's arbitrary determination of benefits for any treatment rendered to me.** I understand no one from my dental office can guarantee payment from my independent third party insurance company.
    - I authorize my insurance company to pay Kennedy Dental directly; however, in the event that my insurance company sends payment directly to me, I will forward the payment within 48 hours. If I fail to send the payment and the office is forced to proceed with the collections process, I will be responsible for any cost incurred by the office to retrieve payment for treatment rendered.

Payment Options:

We accept cash, checks, and most major credit cards. We also work with Care Credit so you can get the care you need, when you need it. On a case-by-case basis, in house financing options may be offered.

Initial Here: _____

LATE CANCELLATION AND MISSED APPOINTMENT POLICY

We understand that sometimes there are emergencies; however, when you fail to keep your appointment or you cancel too close to your appointment me, we are not usually able to fill this time with another patient who is needing dental care. In order to treat all our patients equally and fairly, we have a universal policy regarding missed appointments and late cancellations. This policy is as follows:

A **missed appointment** includes: cancelling within 4 business hours of your appointment, arriving more than 15 minutes late to your appointment, or failing to arrive for your appointment entirely. **For any missed appointment, we reserve the right to charge a fee of $100.** This fee will not be covered by insurance and will have to be paid prior to being scheduled for any future appointments.

A **late cancellation** is a cancellation within 48 business hours of your appointment. **For any late cancellation, we reserve the right to charge a fee of $50.**

If you have two missed appointments and/or late cancellations in a 12 month period, we may: require a **non-refundable** $100 deposit to reserve your appointment (which may be applied toward your treatment if you keep your appointment that day) or require appointments to be made "same-day" where you call on a day you are available to see if there are openings in the schedule. Note: There are no guarantees that we will be able to accommodate you, but we will always try our best.

Initial Here: _____

ACKNOWLEDGEMENT OF CONSIDERATE CARE

I understand my dental team is committed to providing me the highest quality care in the most comfortable environment. I acknowledge that I am entitled to considerate, courteous, and respectful treatment. My dental team will provide reasonable accommodations for emergency care. I understand for the safety and protection of all, security cameras are in use throughout the office which record both visual and audio input. My team complies with all **ADA, CDC, & OSHA regulations** to provide a clean and safe environment for all dental visits. I understand I may seek a second opinion at any time and request a copy of my digital X-rays WITHOUT incurring any additional fees. I understand that I am entitled to **privacy** and **confidentiality** in discussions, examinations, and treatment.

In exchange for providing considerate care, I agree to treat all members of the Kennedy dental team and other patients at the office with respect. I understand that any inappropriate language or behavior will not be tolerated and will be grounds for my dismissal from the office.

Initial Here: _____

By signing this form, I acknowledge that I have read, understand, and agree to the terms and conditions of the notice of privacy practices and office policies.

Printed Name: _____

Signature: _____ Date: _____

MEDICAL HISTORY

What is your estimate of your general health? _____
Date of most recent physical examination: _____
Purpose: _____
Physician/Provider Name: _____ Specialty: _____

Weight: _____ Height: _____

Have you ever been hospitalized for illness or injury? Y/N; If yes, describe: _____
_____

Allergic or bad reaction to any of the following (circle all that apply):

Aspirin
Ibuprofen
Acetaminophen
Codeine
Penicillin
Erythromycin
Tetracycline
Sulfa
Local Anesthetic
Fluoride
Chlorhexidine
Latex
Nickel
Gold
Silver
Titanium
Nuts
Fruit
Milk
Red dye
Other

Have you ever had any of the following (circle all that apply)

Heart
- Heart problems w/in last 6 months
- Heart problems over 6 months
- History of infective endocarditis
- Artificial heart valve
- Repaired heart defect
- Pacemaker
- Implantable defibrillator
- Heart murmur

Surgical History
- Organ transplant
- Joint replacement

Rheumatic Fever/Scarlet fever
High blood pressure
Low blood pressure
Strokes (within last 6 months)
Taking blood thinners
Anemia/other blood disorder
Prolonged bleeding due to slight cut (INR>3.5)

Lungs/Pulmonary
- Pneumonia
- Emphysema
- Shortness of breath while sitting
- Sarcoidosis

Active Infections
- Chronic ear infection
- Tuberculosis
- Measles
- Chicken pox

Breathing Problems
- Asthma-Occasional
- Asthma-Frequent
- Nasal breathing
- Stuffy Nose
- Sinus Congestion

Sleep problems
- Sleep apnea
- Snoring
- Insomnia
- Restless sleep
- Bedwetting

Kidney Disease
- Impaired kidney function
- Kidney stone

Liver disease
- Impaired liver function
- Jaundice

Vertigo
Thyroid/Parathyroid Disease
Calcium Deficiency
High cholesterol

Diabetes
- Type I
- Type II
- HbA1c/Average Blood sugar: _____

Stomach/duodenal ulcer

Digestive or eating disorders
- Celiac Disease
- Gastric reflux/GERD
- Bulimia
- Anorexia
- Irritable Bowel Syndrome
- Crohn's
- Other: _____

Bone Disorders
- Osteoporosis
- Osteopenia
- Taking bisphosphonates (Fosamax, Prolia, etc.)
- Ever taken anti-resorptive medications

Arthritis
Gout
Rheumatoid Arthritis
Lupus
Scleroderma
Glaucoma

Head injuries
Neck injuries

Epilepsy (seizures)
- Controlled
- Frequent

Alzheimer's Disease
Dementia
Prion disease
Viral infections
Cold sore
Bacterial infections
Lyme disease
Lumps in the mouth
Swelling in the mouth

Hives
Skin Rash
Hay Fever
Other skin disease

Infectious Disease
STI
STD
HPV
Hepatitis
- Type A
- Type B
- Type C

HIV
AIDS

Cancer History
Tumor
Abnormal growth
Radiation therapy
Chemotherapy
Immunosuppressive medication

Behavioral History
- Difficulties with stress management
- Psychiatric treatment
- Antidepressant medication
- Mood stabilizing medications
- Occasional alcohol consumption (1 to 4 drinks/week)
- Daily alcohol consumption
- Recreational drug use
- Often exhausted/fatigued
- Experiencing chronic pain
- Experiencing frequent headaches
- Experiencing chronic pain
- A smoker
- Used to smoke
- Use smokeless tobacco
- Vaping/E-cigarette use
- Use Cannibis

Women
Pregnant
Breastfeeding

Please list any medications or supplements that you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____