Kathleen C Green Naughton, DMD, PC
7500 E McDonald Dr, Suite 101B
Scottsdale, AZ. 85250
480.993.9045
KGNDental.com

Family Dentistry

WELCOME TO OUR PRACTICE!

Patient Information

Date:_____
Patient Last Name:_____
Patient First Name:_____ Prefer to be called:_____
Patient Date of Birth:_____ Age:_____ Sex: Male/Female
Patient Phone:_____ Consent to Text: Yes/No (reminders, billing)
Address: _____, _____, _____, _____
street city state zip
E-mail: _____Consent to Communications: Yes/No (reminders, billing)
Occupation/School:_____
Whom may we thank for referring you?_____
Emergency contact Name: _____ Relationship_____
Phone:_____

DENTAL INSURANCE

Who is responsible for this account?:_____ Relationship _____
If spouse: Spouse Birthdate _____
Insurance Company:_____
Group Number:_____ Member Number:_____
Employer:_____
Do you have additional dental insurance? Yes/No. If so:
Who is responsible for this account?:_____ Relationship _____
If spouse: Spouse Birthdate _____
Insurance Company:_____
Group Number:_____ Member Number:_____
Employer:_____

Assignment and release

I certify that I, and/or my dependent(s), have insurance coverage with the above Insurance Company(ies) and assign directly to Kathleen C Green Naughton, DMD, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr Kathleen C Green Naughton may use my health care information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or until revoked.

Patient Name (printed):_____ Date:_____
Patient/Guardian Signature:_____

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POLICIES

Appointment Policy

An appointment is time reserved specifically for you. Please be punctual, appointments are based on the time needed for each service. We reserve the right to refuse to treat any patient who misses or is late to appointments. Although a patient with an emergency may necessitate assistance, we do our best to run on schedule. If we are running late, we will contact you. We know your time is valuable too. It is our policy to charge up to $100 for any missed appointment, or those that are not cancelled at least 24 hours in advance.

Financial Policy

Our financial policy is intended to facilitate excellent personal service while minimizing administrative costs. All charges you incur for your treatment are your responsibility. Payment is due at time of service. If you have insurance, your estimated co-payment is due at time of service.

As a courtesy, if you are using insurance, we will file your claim to your insurance carrier; however, if the insurance company does not pay within 90 days, the full balance will become your responsibility.

Please note: We are a family centered practice. We understand that unanticipated dental expenses happen and can strain finances. If this happens, please speak with us. With honest communication, we can usually work our acceptable arrangements.

Treatment Consent

I have read and understand the above policies. I consent for the office of Kathleen C Green Naughton, DMD, PC to provide dental care.

Patient Name (printed):_____ Date:_____
Patient/Guardian Signature:_____

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Dental History

Reason for today's visit:_____
Are you happy with your smile?_____
Last dentist_____ City/State_____ Last Visit_____

Last dental X-rays:_____

please forward any current X-Rays to the above address or info@KGNDental.com

How often do you brush?_____ floss?_____

Please circle if you have or had any of the following:

Pain	Sensitivity to Cold/ Heat/Sweet/Biting	Sores/growths in your mouth	Swelling	Swollen or tender gums	Difficulty chewing
Loose teeth	Broken fillings	Pain around ear	Bad breath	Bleeding gums	Blisters on lips/in mouth
Burning sensation on tongue	Chewing on one side of mouth	Cigarette/cigar/ pipe/vape smoking	Fingernail biting	Clicking or popping jaw	Food collection between teeth
Foreign objects/piercings in/around mouth	Grinding/Clenching teeth	Dip/chew tobacco	Lip/Cheek biting	Mouth breathing	Periodontal treatment
Orthodontic treatment	Brux/Night Guard	Sports Guard	Whitening		

Is there anything else we should know:_____

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MEDICAL HISTORY

Physician's Name:_____ Phone:_____Last visit:_____
Medications:_____
Pharmacy Name: _____ Phone:_____
Please circle if you have any of the following allergies: Latex, Penicillin, Sulfa, Aspirin, Codeine, Iodine, Barbiturates, Local Anesthetic, Alcohol, Other:_____

Please circle if you have had or are currently experiencing any of the following:

Abnormal Bleeding with past extraction, surgery, or injury	Cortisone Treatments	Headaches / Migraines	Diabeties	Chemical Dependency
Anemia	Back Problems	Hepatitis -Type___	Jaundice	Nervous Problems
Artificial Heart Valve(s) Date placed:_____	Artificial Joints Date placed:_____	Thyroid Problems Hyper/Hypo/Removed	Glaucoma	Skin Rash
Blood Disease	Cancer	Cough (perisitant/ bloody)	Epilepsy	Special Diet
Pacemaker	Radiation	Shortness of Breath	Liver Disease	Psychiatric Care
Congenital Heart Lesions	Chemotherapy	Emphysema	Kidney Disease	Tuberculosis
Heart Murmur	Leukemia	Asthma	Vision Correction	Rheumatic Fever
Mitral Valve Prolapse	Fainting/Dizziness	Sinus Trouble	Ulcer	Scarlet Fever
High Blood Pressure	Arthritis/Rheumatism	Swollen Neck Glands	AIDS/HIV	Stroke
Low Blood Pressure	Circulatory Problems	Respiratory Disease	Herpes	Jaw Pain
Heart Problems:_____	Swollen Feet or Ankles	Tonsillitis	Trauma	Other:
Have you ever used a bisphosphonate medication (EG Fosamax, Actonel, Atelvia, Boniva)? YES/NO	Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" YES/NO	Women: Pregnant: Yes/ No Due:_____ Nursing:Yes/No Birth Control? Yes/No	Do you have any additional concerns or comments?	

Is there anything else we should know?_____

Office Use Only
Reviewed and Signed by: _____ Date_____
Updated:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

If you have printed this from KGNDental.com,
a copy of the Notice of Privacy Practices is available at the office.

I have received a copy of this office's Notice of Privacy Practices.

Patient Name (printed):_____ Date:_____
Patient/Guardian Signature:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our
Notice of Privacy Practices, however
Acknowledgement could not be obtained because (check):

___ Individual refused to sign.
___ Communication barriers prohibited obtaining the acknowledgement.
___ An emergency situation prevented us from obtaining acknowledgement.
___ Other: _____.