KANNAPOLIS
FAMILY DENTISTRY

Patient Information

Patient Name:_____ Date:_____
Last, First MI (Preferred Name)

Gender: _____Family Status:_____Email_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Cell)_____ (Work):_____ Ext

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact:_____Phone_____

Health Information

Date of Last Dental Visit: Reason for this visit:

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies_____
- _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ _____
- ☐ _____

● List current medications: _____

_____

_____

· Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:

· Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:

· Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:

· Name of Physician: _____ Phone:

· Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:
Signature of patient, parent or guardian

Referral Information

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

Responsible Party Information

Name:

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Mobile): _____

Address:_____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name: _____

Address:_____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of

said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient:
Signature of guarantor of payment/responsible party

KANNAPOLIS
FAMILY DENTISTRY

Financial Agreement

Thank you for choosing Kannapolis Family Dentistry as your dental provider. We are committed to providing you and your family with the best dental care possible. In our ongoing process to make sure that all of your dental needs are met, our billing department will be available to discuss our fees and this policy with you.

Payments for all services are due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit. As a courtesy to you, it is the policy of Kannapolis Family Dentistry to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

- Your insurance policy is a contract between you, your employer, and the insurance company. We are not party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, and secondary insurance charges. As your dental provider, we will only supply factual information to facilitate claim processing.
- Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and/ or service fees.
- All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is made directly to you for services billed by Kannapolis Family Dentistry, you recognize an obligation to promptly remit payment to Kannapolis Family Dentistry.
- I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Kannapolis Family Dentistry I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

At Kannapolis Family Dentistry we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call (704) 933-2116.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW.

Printed Name of Patient:_____ Date: _____

Signature of Patient or Responsible Party: _____

KANNAPOLIS FAMILY DENTISTRY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____ have received a copy of this office's Notice of
(Please Print Name) Privacy Practices.

_____
(Signature)

_____
(Date)