Please Print

Date: Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT INFORMATION

Last Name: First Name: Middle Initial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: ( ) Cell Phone: ( ) Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Occupation:

City: State: Zip Code:

How did you hear about our office?

 Emergency Contact Name: Phone Number:

PRIMARY INSURANCE

Responsible Party:

Relation to Patient: Birthdate: Soc. Sec. #:

Address if different from Patient:

City: State: Zip:

Subscriber’s Employer:

Insurance Company:

Group Number: Member/Subscriber I.D.#:

ASSIGNMENT AND RELEASE/ FINANCIAL POLICY

I certify that I, or my dependent(s) have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and assign directly **to Dr. Yvonne Kinkopf, D.B.A. Stow Smiles Family Dental Care** 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 my insurance. I authorize the user of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I understand that my co-pays are due at the time of service unless other prior arrangements have been made. I understand that credit card payments are accepted in person only. Due to increased credit card security measures, the card must be present and swiped/inserted at time of payment.

I understand that this office does not perform amalgam restorations. If my insurance company downgrades their payment of composite (white) fillings to the amount they would pay for a silver filling, I am responsible for the remaining balance.

Signature of Patient, Parent or responsible party Date

Printed Name Relation to Patient

DENTAL HISTORY

Reason for Today’s Visit Date of Last dental Care

Do you have any of the following concerns:

Bad Breath

Bleeding gums

Clicking or popping jaw

Food collection between teeth

Grinding/clenching teeth

Loose teeth or broken fillings

Periodontal treatment

Sensitive teeth

Sores or growths in your mouth

Snoring

Other:

MEDICIAL HISTORY

Physician’s Name Last Visit

Currently Under a Doctor’s Care? For:

Do you or have you ever had:

Anemia

Arthritis/rheumatism

**Artificial heart valve**

**Artificial joints**

Asthma

Back problems

Blood diseases

Cancer, **chemotherapy**

**Chemical dependency**

Circulatory problems

**Steroid or cortisone treatment**

Cough, persistent

Cough up blood

Diabetes

Epilepsy

Fainting

Glaucoma

Headaches

Heart murmur

**Heart problems**

Hemophilia

Hepatitis

High blood pressure

HIV/AIDS

Jaw pain

Kidney disease

Pacemaker

**Radiation treatment**

Respiratory disease

Shortness of breath

Skin rash

Stroke

Swelling of the feet or ankles

Thyroid problems

Tuberculosis (TB)

Ulcers

Venereal Diseases

MEDICATIONS

List any medications you are taking:

(Women) Are you Pregnant? Nursing? **Taking Oral Contraceptives**?

**Have you ever taken osteoporosis medications**? (Fosamax, Boniva, etc.)

**Do you take any blood thinners**?

ALLERGIES

Aspirin

Codeine

Penicillin

Sulfa

Latex

Other

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold Yvonne B. Kinkopf DDS or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: Date: