KANNING DENTAL
a family practice

# PATIENT AND INSURANCE FORM

Patient First Name: _____ Middle Initial: ____ Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ May we send you text messages? ❒ Yes ❒ No

E-mail Address: _____ Birth Date: _____ Gender: ❒ Male ❒ Female

Employer: _____ Work Phone: _____ Social Security Number: _____

Marital Status: ❒ Minor ❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Engaged ❒ Domestic Partnership

## SPOUSE'S INFORMATION ❒ Not Applicable

Name: _____ Birth Date: _____ Social Security Number: _____

Phone Number: _____ May we share your protected health information with your spouse? ❒ Yes ❒ No

May we link your account with your spouse's? ❒ Yes ❒ No

## PARENT/GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

Mother's First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Father's First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

** I understand that by signing below I am financially responsible for the patient listed at the top of this form and that I have read and understand the Payment/Co-Pay section on the back page.*

Signature: _____ Date: _____

## PRIMARY DENTAL INSURANCE

Insurance Company: _____ Plan Number: _____ Subscriber ID Number: _____

Insured Name: _____ Insured Birth Date: _____

Insured Social Security Number: _____ Employer: _____

## SECONDARY DENTAL INSURANCE

Insurance Company: _____ Plan Number: _____ Subscriber ID Number: _____

Insured Name: _____ Insured Birth Date: _____

Insured Social Security Number: _____ Employer: _____

*(Continued on back)*

**How did you hear about us?** ❒ Insurance List Mailer ❒ Google/Bing/Yahoo ❒ Billboard ❒ Drive by/Live close ❒ Facebook

❒ Friend/Relative: _____ ❒ Other: _____

***Payment/ Co-Pay:** I understand payment is due in full the day services are provided. I understand the office does not offer any payment plans other than through a finance company. I understand all fees are due in full on the date of service, (even if more than one appointment is required to finish the procedure, i.e. dentures, partials, crowns, etc.). Payment can be made by cash, check, and credit / debit card or financing through a third party financing company, with approved credit. I agree that if collection problems arise, I am liable for all collection fees, including attorney fees, court costs and late charges. I understand that quotes/ treatment plan amounts with insurance are only an estimation and I am ultimately responsible for all fees incurred for the patient listed on page one of this form.

**Cancellation Policy:** Appointment time is reserved specifically for you. When patients are unable to show up for their appointments it prevents other patients from being seen in a timely manner and takes that reserved time from other patients. We understand last minute changes can occur and we will be happy to reschedule you. However, please contact our office by noon (12:00 pm) two business days prior to your appointment if you are unable to make your reserved time.

Repeated no shows or cancellations may result in up to a $50 no show charge which is not covered by your insurance and must be paid prior to reserving future appointment time.

**Consent:** I give my consent to be seen by the doctor. If I elect treatment, I consent for the work to be done. I understand that during the course of the procedure(s) unforeseen conditions may arise which necessitate procedures other than contemplated. I am aware there may be additional charges associated with the new treatment. I understand that the treatment plan/options I was given is just an estimation and the actual amount of my treatment could differ from the amount originally quoted. I trust that the doctor has given me the closest possible estimation and I will be informed of any additional costs that are incurred.

**HIPAA:** I have reviewed and acknowledged the Notice of Privacy Practices for the office and consent for use and disclosure of health information. I have notated on page one of this form whether or not the office may share my protected health information and account information with my spouse (if applicable) and one other person I have listed. I understand if I wish for the office to share my protected health or account information with anyone other than my spouse or the other person I have listed on page one, I will need to complete and sign a separate form.

Patient Signature: _____ Date: _____

**AUTHORIZATION FOR TREATMENT OF A MINOR**

If patient is under the age of 18, a parent or guardian must read and sign below:

I, being the parent or guardian of the above named minor patient, do hereby authorize and request the performance of services for this patient; and further, the performance of whatever procedures the judgment of Dr. Kanning may deem necessary during the performance of any operation. I also authorize the administration of anesthetics or analgesics, to include nitrous oxide analgesia, which may be deemed advisable by the doctor.

Guardian Signature: _____ Date: _____

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# MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Name of Physican(s) and their specialty: _____

Date of most recent physical examination: _____ What is your general health: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

## DO YOU HAVE or HAVE YOU EVER HAD:

| | YES | NO |
|---|---|---|
| Hospitalization | ❒ | ❒ |
| What: _____ | | |
| Date: _____ | | |
| Illness | ❒ | ❒ |
| What: _____ | | |
| Date: _____ | | |
| Injury | ❒ | ❒ |
| What: _____ | | |
| Date: _____ | | |

| An allergic reaction to | YES | NO |
|---|---|---|
| Aspirin/Ibuprofen/Acetaminophen | ❒ | ❒ |
| Penicillin/Erythromycin/Tetracycline | ❒ | ❒ |
| Codeine/Valium/Hydrocondine/Oxycodine | ❒ | ❒ |
| Sulfa | ❒ | ❒ |
| Local Anesthetic/Epinepherine | ❒ | ❒ |
| Metals (nickel/gold/silver) | ❒ | ❒ |
| Latex | ❒ | ❒ |
| Other: _____ | ❒ | ❒ |

| | YES | NO |
|---|---|---|
| Heart problems or cardiac stint within the last 6 months | ❒ | ❒ |
| History of infective endocarditis | ❒ | ❒ |
| Artificial heart valve, repaired heart defect (PFO) | ❒ | ❒ |
| Pacemaker or implantable defibrillator | ❒ | ❒ |
| Artificial joint | ❒ | ❒ |
| Rheumatic or scarlet fever | ❒ | ❒ |
| High or low blood pressure | ❒ | ❒ |
| A stroke (taking blood thinners) | ❒ | ❒ |
| Anemia or other blood disorder | ❒ | ❒ |

| | YES | NO |
|---|---|---|
| Prolonged bleeding due to a slight cut (INR>3.5) | ❒ | ❒ |
| Emphysema, shortness of breath, sarcoidosis | ❒ | ❒ |
| Asthma/COPD/other lung disease | ❒ | ❒ |
| Breathing/sleep problems (sleep apnea, snoring, sinus) | ❒ | ❒ |
| Kidney disease | ❒ | ❒ |
| Liver disease/jaundice | ❒ | ❒ |
| Thyroid, parathyroid disease, or calcium deficiency | ❒ | ❒ |
| High cholesterol or taking statin drugs | ❒ | ❒ |
| Diabetes (HbA1c = _____) | ❒ | ❒ |
| Digestive disorders (celiac disease, gastric reflux) | ❒ | ❒ |
| Osteoporosis/osteopenia (taking bisphosphonates) | ❒ | ❒ |
| Arthritis, rheumatoid arthritis, lupus | ❒ | ❒ |
| Glaucoma | ❒ | ❒ |
| Head or neck injuries | ❒ | ❒ |
| Epilepsy, convulsions (seizures) | ❒ | ❒ |
| Viral infections and cold sores | ❒ | ❒ |
| Any lumps or swelling in the mouth | ❒ | ❒ |
| STI/STD | ❒ | ❒ |
| Hepatitis (type_____) | ❒ | ❒ |
| HIV/AIDS | ❒ | ❒ |
| Tumor, abnormal growth/cancer | ❒ | ❒ |
| Radiation therapy | ❒ | ❒ |
| Chemotherapy, immunosuppressive therapy | ❒ | ❒ |
| Psychiatric treatment | ❒ | ❒ |
| Antidepressant medication | ❒ | ❒ |
| Recreational drug use | ❒ | ❒ |

| ARE YOU: | YES | NO |
|---|---|---|
| Presently being treated for any other illness | ❒ | ❒ |
| Taking medication for weight management | ❒ | ❒ |
| Often exhausted or fatigued | ❒ | ❒ |
| Experiencing frequent headaches | ❒ | ❒ |
| Female, taking birth control pills | ❒ | ❒ |
| Female, pregnant or nursing | ❒ | ❒ |

*(Continued on back)*

## ARE YOU TAKING ANY OF THESE MEDICATIONS:

| | YES | NO |
|---|---|---|
| Pre-medication before dental treatment | ❒ | ❒ |
| St. John's Wort of Kava-Kava | ❒ | ❒ |
| Antacids | ❒ | ❒ |
| Dilantin or Tegretol | ❒ | ❒ |
| Barbiturates (any) | ❒ | ❒ |
| Tagment (cimetidine) or Prilosec (omeprazole) | ❒ | ❒ |
| Cardizem (diltiazem) or Calan, Isoptin (Verapamil) | ❒ | ❒ |
| Serzone (nefazodone) | ❒ | ❒ |
| Diflucan (fluconazole) or Sporonox (itraconazole) | ❒ | ❒ |
| Biaxin (clarithromycin) | ❒ | ❒ |

| | YES | NO |
|---|---|---|
| Antacids | ❒ | ❒ |
| Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva, Reclast) or PROLIA | ❒ | ❒ |
| If so when did the treatment begin _____ | | |
| When did the treatment end _____ | | |
| Have you ever taken any prescription drugs such as fen-phen for weight loss | ❒ | ❒ |
| Do you consume grapefruit juice, grapefruits or grapefruit extract? | ❒ | ❒ |

Please list any current medical treatment, impending surgery, genetic/development delay, or other treatment that my possibly affect your dental treatment (i.e. Botox, collegen injections): _____

_____

_____

_____

_____

_____

List any medications, supplements, and/or vitamins taken within the last two years (include dietary or herbal supplements):

| DRUG | DOSAGE | PURPOSE |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

### TOBACCO, ALCOHOL, DRUGS

Do you use tobacco: ❒ Yes ❒ No; If yes, what type: ❒ smoke ❒ chew; How much per day: _____ For how long: _____

Do you want to quit using tobacco: ❒ Yes ❒ No

Do you consume alcohol: ❒ Yes ❒ No; If yes, how many alcoholic beverages per week: _____

Do you use any mood altering drugs other than those previously listed: ❒ Yes ❒ No; If yes, what type: _____

### WEIGHT AND DIET

Weight: _____ Height: _____ Food Allergies: _____

Meals per day: _____ Dietary Restrictions: _____

Sugar in your diet: ❒ None ❒ Slight ❒ Moderate ❒ High

*I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in any heath and medication.*

Patient/Guardian Signature: _____ Date: _____

# DENTAL HISTORY FORM

Patient Name: _____ Date: _____

Referred by: _____ Previous Dentist: _____ How long: _____

Date of most recent dental examination: _____ Date of most recent x-rays: _____

How would you rate the condition of your mouth: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

I routinely see my dentist every: ❒ 3 months ❒ 4 months ❒ 6 months ❒ 12 months ❒ Not routinely

What is your immediate concern: _____

| **PERSONAL HISTORY:** | **YES** | **NO** |
|---|---|---|
| • Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most) | ❒ | ❒ |
| • Have you had an unfavorable dental experience? | ❒ | ❒ |
| • Have you ever had complication from past dental treatment? | ❒ | ❒ |
| • Have you ever had trouble getting numb or had any reactions to local anesthetic? | ❒ | ❒ |
| • Did you ever have braces, orthodontic treatment, or had your bite adjusted? | ❒ | ❒ |
| • Have you had any teeth removed? | ❒ | ❒ |

| **GUM AND BONE:** | | |
|---|---|---|
| • Do your gums bleed or are they painful when brushing or flossing? | ❒ | ❒ |
| • Have you ever been treated for gum disease or been told you have lost bone around your teeth? | ❒ | ❒ |
| • Have you ever noticed an unpleasant taste or odor in your mouth? | ❒ | ❒ |
| • Is there anyone with a history of periodontal disease in your family? | ❒ | ❒ |
| • Have you ever experienced gum recession? | ❒ | ❒ |
| • Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? | ❒ | ❒ |
| • Have you experience a burning sensation in your mouth? | ❒ | ❒ |

| **TOOTH STRUCTURE:** | | |
|---|---|---|
| • Have you had any cavities within the past 3 years? | ❒ | ❒ |
| • Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? | ❒ | ❒ |
| • Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? | ❒ | ❒ |
| • Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? | ❒ | ❒ |
| • Do you have grooves or notches on your teeth near the gum line? | ❒ | ❒ |
| • Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? | ❒ | ❒ |
| • Do you frequently get food caught between any teeth? | ❒ | ❒ |

| **BITE AND JAW JOINT:** | | |
|---|---|---|
| • Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping) | ❒ | ❒ |
| • Do you feel like your lower jaw is being pushed back when you bite your teeth together? | ❒ | ❒ |
| • Do you avoid or have difficulty chewing gum, carrots, bagels, steak, or other hard, dry foods? | ❒ | ❒ |
| • Have your teeth changed in the last 5 years, become shorter, thinner, or worn? | ❒ | ❒ |
| • Are your teeth crowding or developing spaces? | ❒ | ❒ |
| • Do you have multiple bites or feel that your teeth do not come together comfortably? | ❒ | ❒ |
| • Do you chew ice, bite your nails, use you teeth to hold objects, or have any other oral habits? | ❒ | ❒ |
| • Do you clench your teeth in the daytime or make the sore? | ❒ | ❒ |
| • Do you have any problems with sleep or wake up with an awareness of your teeth? | ❒ | ❒ |
| • Do you wear or have you ever worn a bite appliance? | ❒ | ❒ |

| **SMILE CHARACTERISTICS:** | | |
|---|---|---|
| • Is there anything about the appearance of your teeth that you would like to change? | ❒ | ❒ |
| • Have you ever whitened (bleached) your teeth? | ❒ | ❒ |
| • Have you felt uncomfortable or self conscious about the appearance of your teeth? | ❒ | ❒ |
| • Have you been disappointed with the appearance of previous dental work? | ❒ | ❒ |

Patient/Guardian Signature: _____ Date: _____

# PREFERENCE FORM

Patient Name: _____ Date: _____

## TELL US YOUR PREFERENCES

We can better recommend the most suitable preventative and corrective treatment for your individual needs, desires and values if we understand what you want for yourself. In other words, we can't represent your best interests if we don't know what your best interests are. Please help us personalize your care to meet your expectations by indicating your preferences or opinion below. Of the statements below, please check the box next to the statement that most represents YOU!

**CHOOSE ONE IN EACH PAIR:**

- ❒ I know a great deal about my dental condition.
- ❒ I know very little about my dental condition.

- ❒ I like to be presented with few options.
- ❒ I like to be presented with more options.

- ❒ I tend to look at the details.
- ❒ I tend to look at the big picture.

- ❒ I prefer long lasting solutions that may cost more.
- ❒ I prefer more temporary solutions at lower cost.

- ❒ I prefer to talk in technical terms.
- ❒ I prefer to talk in non-technical terms.

- ❒ My insurance largely determines the extent of my care.
- ❒ I largely determine the extent of my care.

- ❒ I prefer to wait until I must act.
- ❒ I prefer a preventative approach and usually see no reason to delay care.

- ❒ I rely more on self-maintenance.
- ❒ I rely more on professional maintenance.

- ❒ I like newer, more modern techniques.
- ❒ I prefer tried and true methods.

- ❒ I favor a treatment oriented approach to disease.
- ❒ I prefer a cause oriented approach to disease.

- ❒ I prefer an authoritarian doctor/hygienist who tells me what I need.
- ❒ I prefer a consultative doctor/hygienist who empowers my autonomy.

- ❒ I prefer to make lifestyle changes.
- ❒ I prefer clinical cures.

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In order of importance, I consider the following benefits of dental health. Please rank 1 (most important) through 7 (least important):

___ Comfort ___ Health ___ Longevity ___ Function ___ Appearance ___ Peace of Mind ___ Other: _____

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## THESE ARE THINGS IMPORTANT TO ME ABOUT MY DENTAL HEALTH

**CHOOSE ONE IN EACH SET:**

**MY MOUTH IS:**
- ❒ Very comfortable
- ❒ Moderately comfortable
- ❒ Uncomfortable

**THE APPEARANCE OF MY MOUTH IS:**
- ❒ Excellent
- ❒ Satisfactory
- ❒ Unsatisfactory

**MY NATURAL TEETH**
- ❒ I will do anything to keep them
- ❒ I want to keep them, but have a certain budget of time and money I am willing to spend on them
- ❒ I don't care whether I keep my teeth or not

**MY ORAL HEALTH GOALS:**
- ❒ I have set goals with a previous dentist
- ❒ I want to set goals concerning my dental health
- ❒ I have never set goals concerning my dental health

**MY DENTAL HISTORY:**
- ❒ I have always done what was recommended for my dental health
- ❒ I have not done what was recommended for my dental health
- ❒ I rarely go to the dentist

**MY DENTAL PRIORITY:**
- ❒ I put dentistry for myself and my family high on my priority list
- ❒ I put dentistry for myself and my family low on my priority list
- ❒ I put dentistry on my list, but it's hard to find

**MY PRESENT STATE OF DENTAL HEALTH:**
- ❒ Excellent
- ❒ Good
- ❒ Poor

**I WANT A MOUTH WITH:**
- ❒ Excellent health
- ❒ Good health
- ❒ Poor health