Kluth Richardson Family and Cosmetic Dentistry

PLEASE PRINT

Patient Info:

Name: _____ Preferred Name: _____
Birthdate: _____ Social Security Number: _____
Male: _____ Female: _____Child: _____ Single: _____ Divorced: _____ Married: _____
Address: _____ City: _____
State, Zip: _____ Employer: _____
Cell#: _____Work#: _____
Home#: _____ Email: _____
Where can we contact you between the hours of 8-5? _____
How did you hear about our office?_____
Is anyone in your household a current patient at our office? YES NO
Name: _____
Emergency Contact Phone: _____
Emergency Contact Name/Relationship to you:_____

Responsible Party Info:

Name: _____ Birthdate: _____
Address: _____ City: _____
State, Zip: _____ Best Phone #:_____
Insurance Primary: ***(Present your Insurance Card and Photo ID to Front Desk.)***
Insured Name: _____ Insured Date of Birth:_____
Relationship to patient: _____ Insured Social Security Number: _____
Insurance Company Name: _____ Insurance ID#: _____
Place of Employment of the insured: _____
Phone number for insured's employer: _____

Previous Dentist Name & Address: _____
Last Visit: _____ How would you rate your smile 1-10? _____
What would you change about your smile? _____

Medical History:

Name of physician: _____ Phone#: _____
Last visit with Physician: _____ Address: _____
Do you smoke? YES NO Do you use chewing tobacco: YES NO

Do you vape? YES NO Do you use a juul? YES NO

Do you or have you ever been told you snore? YES NO

Are you currently taking prescription or non-prescription medication? : YES NO

If yes, please list: _____

_____
_____
_____

Have you ever had, or been treated for any of the following: ***CIRCLE ALL THAT APPLY***

Psychiatric Problems	Tuberculosis	Heart Attack	Stroke	Hepatitis	Epilepsy
Cancer	Aids/HIV	Heart Murmur	Anemia	Kidney problems	
High Blood Pressure	Diabetes	Abnormal Bleeding	Drug Alcohol abuse	Artificial Joints	

Have you been treated for any other illness not listed? YES NO
If yes, please explain further: _____
_____

Have you been instructed by your physician to take a pre-medication (antibiotic) before dental appointments? (For medical conditions such as, artificial joint, hear problems, etc.) YES NO
If yes, what antibiotic des your physician require you to take: _____
Do you take medication that are Bisphosphates/ or medication for osteoporosis? _____
Would you be interested in receiving information about medication we can give you before a procedure to relax you or make your anxiety less severe? ***(Some do require a driver)*** YES NO

Allergies: **(Circle all that apply)**	Penicillin	Aspirin	Codeine	Erythromycin
	Latex	Sulfa	Dental Anesthetic	

Please list other allergies: _____

Women only:

Are you pregnant? YES No Due Date: _____
Are you nursing at this time? _____
Are you taking any hormone replacement therapy?_____

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a through diagnosis for my dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to use all anesthetics, sedatives and other medications as the doctor deems necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete copy of any possible complications
4. I agree to be responsible for payment of all services rendered on mine or my dependents behalf. I understand payment is due upon time of service. I understand if insurance has not paid within 90 days, the balance is my responsibility. I understand interest and a late fee cold be assessed to any outstanding balance on my account. I also agree that should it be needed, I will be responsible for any and all collection costs, which may include but are not limited to attorney fees, collection costs and court costs.
5. I understand that a 48 hour notice must be given to cancel or reschedule an appointment. I realize that a $30.00 fee may be assessed to my account if I fail to give proper notice. I realize that the doctor has the right to refuse to save time for me again in the schedule if I fail to give a 48 hour notice. If more than 3 appointments are missed or reschedule on short notice the doctor reserves the right to dismiss you as a patient from this office. If this does happen your records will be sent to another dentist of your choice.
6. I also give permission for the doctor or his staff to use any photos they may take for lecturing, education or promotional purposes.
7. PLEASE UNDERSTAND THAT YOU ARE RESPONSIBLE FOR KNOWING AND UNDERSTANDIGNG YOUR INSURANE LIMITATIONS AND BENEFITS.

Printed Name of Patient: _____ Date: _____

Signature: _____