BRYAN A. KREEB D.D.S. KELLY W. KREEB D.D.S.

1 PATIENT INFORMATION

Date ______________

Patient ______________

Address ______________

____
City State Zip

Sex: ❑ M ❑ F Age ________ Birthdate ________

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# ______________

Occupation ______________

Employer ______________

Email ______________

Would you like to receive email correspondence? ☐ YES ☐ NO

Spouse's Name ______________

Birthdate ________ SS# ________

Occupation ______________

Spouse's Employer ______________

Whom may we thank for referring you? ______________

____

2 DENTAL INSURANCE

Who is responsible for this account? ______________

Relationship to Patient ______________

Insurance Co. ______________

Group # ______________

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name ______________

Birthdate ________ SS# ________

Relationship to Patient ______________

Insurance Co. ______________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________ and assign directly to Dr. ______________ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

____
Relationship Date

3 PHONE NUMBERS

Home ________ Work ________ Cell ________ Spouse's Work ________

Best time and place to reach you ______________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______________ Relationship ______________

Home Phone ______________ Work Phone ______________

4 MEDICATIONS

List medications you are currently taking:

____

____

____

Pharmacy Name ______________

Phone ______________

ALLERGIES

❑ Aspirin
❑ Local Anesthetic
❑ Barbiturates (Sleeping Pills)
❑ Penicillin
❑ Codeine
❑ Sulfa
❑ Iodine
❑ Other ______________
❑ Latex

____

Reason for Today's Visit:

____

____

5 HEALTH HISTORY

Physician's Name ________________________ Date of Last Visit ____________

Please mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No
AIDS	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No
Bleeding Abnormally with Extractions or Surgery	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No
Circulatory Problems	❑ Yes	❑ No
Congenital Heart Lesions	❑ Yes	❑ No
Cortisone Treatments	❑ Yes	❑ No
Cough, Persistent or Bloody	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No
Do you wear contact lenses?	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No
Fainting or dizziness	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Headaches	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
Heart Problems	❑ Yes	❑ No
Hepatitis Type ________	❑ Yes	❑ No
Herpes	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
HIV Positive	❑ Yes	❑ No
Jaundice	❑ Yes	❑ No
Jaw Pain	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No
Liver Disease	❑ Yes	❑ No
Low Blood Pressure	❑ Yes	❑ No
Mitral Valve Prolapse	❑ Yes	❑ No
Nervous Problems	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No
Women: Are you pregnant?	❑ Yes	❑ No
Are you nursing?	❑ Yes	❑ No
Due Date ________		
Psychiatric Care	❑ Yes	❑ No
Radiation Treatment	❑ Yes	❑ No
Respiratory Disease	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Scarlet Fever	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
Sinus Trouble	❑ Yes	❑ No
Skin Rash	❑ Yes	❑ No
Special Diet	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
Swelling of Feet or Ankles	❑ Yes	❑ No
Swollen Neck Glands	❑ Yes	❑ No
Thyroid Problems	❑ Yes	❑ No
Tonsillitis	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Tumor or Growth on Head or Neck	❑ Yes	❑ No
Ulcer	❑ Yes	❑ No
Venereal Disease	❑ Yes	❑ No
Unexplained Weight Loss	❑ Yes	❑ No

6 DENTAL HISTORY

Reason for today's visit ____________

____

Former Dentist ____________

City/State ____________

Date of last dental visit ____________

Date of last dental X-rays ____________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No
Bad Breath	❑ Yes	❑ No
Bleeding Gums	❑ Yes	❑ No
Blisters on lips/mouth	❑ Yes	❑ No
Burning Sensation on Tongue	❑ Yes	❑ No
Chew on One Side of Mouth	❑ Yes	❑ No
Cigarette, pipe, or Cigar Smoking	❑ Yes	❑ No
Clicking or Popping Jaw	❑ Yes	❑ No
Dry Mouth	❑ Yes	❑ No
Fingernail Biting	❑ Yes	❑ No
Food Collection Between the Teeth	❑ Yes	❑ No
Foreign Objects	❑ Yes	❑ No
Grinding Teeth	❑ Yes	❑ No
Gums Swollen or Tender	❑ Yes	❑ No
Jaw Pain or Tiredness	❑ Yes	❑ No
Lip or Cheek Biting	❑ Yes	❑ No
Loose Teeth or Broken Fillings	❑ Yes	❑ No
Mouth Breathing	❑ Yes	❑ No
Mouth Pain, Brushing	❑ Yes	❑ No
Orthodontic Treatment	❑ Yes	❑ No
Pain Around Ear	❑ Yes	❑ No
Periodontal Treatment	❑ Yes	❑ No
Sensitivity to Cold	❑ Yes	❑ No
Sensitivity to Heat	❑ Yes	❑ No
Sensitivity to Sweets	❑ Yes	❑ No
Sensitivity when Biting	❑ Yes	❑ No
Sores/Growths in Mouth	❑ Yes	❑ No

How often do you floss? ____________

How often do you brush? ____________

7 COMMENTS

Have you ever had any serious illness not above? ○ YES ○ NO ○ N/A ________________

Comments: ________________________________

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

Authorization and Releases

Legal Responsible Party

If the patient is a minor and/or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient.

Print Name: ____________________________ Signature: ________________________ Date: _______________

Financial Policy

We understand and appreciate your concerns regarding fees associated with your treatment, and feel that you should have a clear understanding of your financial commitment for services provided. We will be happy to discuss fees anytime prior to treatment. And you as our patient, should fully understand our mutual obligations and responsibilities.

Contract to Pay for Medical Services

In consideration of the required professional services provided to the above patient, I/we agree to pay the account for these services in full, at the time of service. I/ we authorize Dr. Kreeb to receive assignment of insurance payments. Any charges in excess of the benefits allowed under the responsible party's insurance plan, I/we understand that I/We are responsible to pay the difference. A finance charge of 1.5% monthly (18% APR) will be added to my outstanding account balance after 30 days. A $40 fee will be applied to patient's accounts for returned checks. A fee can be charged to the patients account if accounts are overdue 60 days, turned over to collection, terminated from the practice. A fee can be charged if appointments are not cancelled 24 hours notice or NO SHOWS. Ask us about outside Financing for treatment costs.

Print Name: ____________________________ Signature: ________________________ Date: _______________

Patients with Insurance

AS A SERVICE TO YOU, WE WILL COMPLETE AND FILE YOUR INSURANCE CLAIM FORMS FOR COMPLETED TREATMENT. YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY; WE ARE NOT A PARTY TO THAT CONTRACT. WE MUST EMPHASIZE THAT AS DENTAL CARE PROVIDERS,OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY, THEREFORE ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED. PLEASE REMEMBER THAT INSURANCE PLANS ARE USUALLY NOT DESIGNED TO PAY FOR EVERYTHING. WE URGE YOU TO READ YOUR POLICY. WE WILL DO OUR UTMOST TO SEE THAT YOU RECEIVE MAXIMUM BENEFITS WITHIN THE STRUCTURE OF YOUR INSURANCE PLAN. **YOUR PORTION OF PAYMENT AND CO-PAY (THE COSTS YOUR INSURANCE WILL NOT COVER) ARE EXPECTED AT THE TIME OF SERVICE.**

Patients with NO Insurance

If you have no insurance, payment for services is expected at the time of treatment. To assist you, we offer the following options for payment: CASH/CHECK or CREDIT CARD (VISA, MASTERCARD, AMEX), Outside Financing Partners - Care Credit.

Authorization to Release Information

Dr. Kreeb is hereby authorized to release any medical or incidental information that may be necessary for medical care, or in processing of my dental insurance.

Notice of Privacy Practices

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office's health care operations. The Notice of Privacy Practices also describes my rights and Dr. Kreeb's duties with respect to my protected health information.

The Notice of Privacy Practices is available in the facility.

Dr. Kreeb reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY **YES** **NO** **SPOUSE ONLY** **YES** **NO**
OTHER (*PLEASE SPECIFY*): **YES** **NO**

Print Name: ____________________________ Signature: ________________________ Date: _______________