KANELLIS FAMILY DENTISTRY

Michael Kanellis DMD

New Patient Information Form

Name:________________________________ ☐Male ☐Female

Home Address:________________________ Home Phone:____________

City, State, Zip:______________________ Cell Phone:____________

Preferred Name:______________________ SSN:____________

Birthdate:______________ Referred by:______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Email:____________

Employer:______________ Occupation:______________

Spouse Name:____________ Parent/Guardian (if minor):____________

Employer:________________________ SSN:____________

Dental Insurance (Primary)

Insured's Name:______________ Employer:______________

Insurance Company:______________ Phone Number:______________

Claim Mailing Address:________________________ Group #:____________

Insured's SSN/ID #:______________ Birthdate:______________

Dental Insurance (Secondary)

Insured's Name:______________ Employer:______________

Insurance Company:______________ Phone Number:______________

Claim Mailing Address:________________________ Group #:____________

Insured's SSN/ID #:______________ Birthdate:______________

Insurance Assignment:

I hereby authorize the above insurance companies to pay the benefits relative to the services performed on my claim to Kanellis Family Dentistry. I understand that I am financially responsible for all charges not covered by insurance.

X________________________________ Date:____________

Consent:

1. I authorize the staff to take radiographs or utilize any other diagnostic aids to make a thorough diagnosis.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for such treatment. I understand that dental treatment and the use of anesthetic agents embodies a certain risk, including but not limited to nerve damage, bleeding, swelling and infection. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that 1 ½ % finance charge (18% APR) may be added to my account.
4. Lastly, I understand that where appropriate, credit bureau reports may be obtained.

Patient X________________________________ **Date:**____________

Guardian (if minor) X______________ **Relationship to Patient:**____________

Please turn page over and complete the back side of the page. Thank you!

MEDICAL INFORMATION

1. Are you in good health? .... Yes No
2. Have you been a patient in the hospital during the last two years?........ Yes No
3. Have you been under the care of a medical doctor during the past year?........ Yes No
   Physician's Name:________________ Phone:________________
4. Have you taken any medication or drugs during the past two years?........ Yes No
5. Are you currently taking any medication or drugs?........ Yes No
   If yes, please list________________
6. Are you currently or have you in the past taken bisphosphonate drugs? (Actonel, Boniva, Fosamax etc.) Yes No
7. Are you allergic or sensitive to any medications or anesthetics?........ Yes No
   If yes, please list________________
8. Do you have any allergies or sensitivities to penicillin, local anesthetics, codeine or aspirin?........ Yes No
9. Do you have any allergies or sensitivities to metals, plastics or latex products?........ Yes No
10. Has a doctor ever told you that you need antibiotics prior to dental treatment?........ Yes No
11. Do you smoke or use tobacco products?........ Yes No
12. Do you use recreational drugs of any sort?........ Yes No

Please indicate which of the following you have at present, or have had. Circle Yes or No to each item.

Heart Failure	Yes No	Cortisone Medication	Yes No	Drug Addiction	Yes No
Heart Disease or Attack	Yes No	Kidney Trouble	Yes No	Hepatitis A (Infectious)	Yes No
Angina Pectoris	Yes No	Ulcers	Yes No	Hepatitis B (Serum)	Yes No
Congenital Heart Disease	Yes No	Diabetes	Yes No	Venereal Disease	Yes No
Heart Murmur	Yes No	Thyroid Problems	Yes No	A.I.D.S.	Yes No
High Blood Pressure	Yes No	Glaucoma	Yes No	H.I.V. Positive	Yes No
Stroke	Yes No	Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No
Arteriosclerosis	Yes No	Emphysema	Yes No	Excessive Bleeding	Yes No
Mitral Valve Prolapse	Yes No	Chronic Cough	Yes No	Blood Transfusion	Yes No
Artificial Heart Valve	Yes No	Sinus Trouble	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Asthma	Yes No	Anemia	Yes No
Heart Surgery	Yes No	Hay Fever	Yes No	Sickle Cell Disease	Yes No
Rheumatic Fever	Yes No	Allergies or Hives	Yes No	Bruise Easily	Yes No
Arthritis	Yes No	Cancer	Yes No	Liver Disease	Yes No
Rheumatism	Yes No	Radiation Therapy	Yes No	Yellow Jaundice	Yes No
Artificial Joints (hip, knee)	Yes No	Chemotherapy	Yes No	Epilepsy or Seizures	Yes No
Orthopedic Surgery (Pins, Plates, Screws)	Yes No	Tumors	Yes No	Fainting or Dizzy Spells	Yes No
		Unexplained Weight Loss	Yes No	Chronic Cough (over 3 weeks)	Yes No
Night Sweats	Yes No	Blood from Coughing	Yes No		

13. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired........ Yes No
14. Have you ever come in close contact or lived in a concentrated housing environment with a Tuberculosis patient? Yes No
15. Do you have any diseases, conditions or problems not listed? .... Yes No
    If YES, please list________________

FOR WOMEN ONLY:	Are you pregnant?	Yes	Due Date: ________________	No
	Are you nursing?	Yes No	Are you taking birth control pills?	Yes No

Do you have a specific dental problem?________________
How long since your last dental visit?________________ Name of previous dentist:________________

Specific Dental Concerns:

Bleeding gums	Yes No	Unpleasant breath or bad taste	Yes No
Loose Teeth	Yes No	Sensitive to Hot, Cold, Sweets, Pressure	Yes No
Sensitive to Biting	Yes No	Clenching or Grinding of Teeth	Yes No
Popping/Clicking of Jaw	Yes No	Food Catching Between Teeth	Yes No
Pain on Opening/Closing	Yes No	Misaligned or Misshapen Teeth	Yes No
Headache or Muscle Pain	Yes No	Discolored Teeth	Yes No

Have you ever had orthodontic treatment?........ Yes No Have you ever been told you have a gum problem?........ Yes No
Have there been any problems or complications related with previous dental treatment?........ Yes No
Does dental treatment make you nervous?........ Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature X________________ **Date:**________________