KEMMET DENTAL DESIGN

LINDELL KEMMET, DDS
1015 S BROADWAY SUITE 24
MINOT, ND 58701
(701) 852-4789

PATIENT INFORMATION:

Today's Date _____/_____/_____

Whom may we thank for referring you?_____ (Person name, reviews, web, etc)

Patient's Name_____ Preferred Name _____

Birth Date _____ Gender: M / F SSN _____--_____--_____

Address _____ City _____ State ___ Zip _____

Phone # _____ _____ _____

(Cell) (Home) (Work)

Patient's Occupation _____

Email Address_____

May we contact you though email and/or text messages to remind you of future appointments? Y / N

Marital status _____

Spouse's name _____

Whom may we contact in case of an emergency?_____ Ph# _____

Primary care physician_____ Ph#_____

DENTAL INFORMATION:

Reason for today's visit _____

Do you have any questions or concerns for the doctor? _____

How would you rate your Smile? (Circle one) Excellent Good Fair Poor Not a Concern

How often do you Brush? _____ Do you Floss? Y / N How often? _____

X_____ Date _____

(Signature of Patient or Guardian if Minor)

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NOTICE of PRIVACY PRACTICES:

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights as a privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may involved in treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

A Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information is available for me to read. I understand that Kemmet Dental Design has the right to change its Notice of Privacy of Practices from time to time and that I may contact Kemmet Dental Design at any time at the above address to obtain a copy of a current Notice of Privacy Practices. Any uses or disclosures not included in this form will be made only with my written permission.
I understand that I may request in writing that you restrict how private my information is used or disclosed to carry out treatment, health operations or payment. I also understand that I am not required to agree to these requested restrictions, but if I do agree then Kemmet Dental is bound to abide by such restrictions.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION
(This includes appointment confirmation, financial and treatment options.)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that I may revoke my authorization at any time, as long as it is done in writing

X_____ Date _____
(Signature of Patient or Guardian if Minor)

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

As an administrative representative at Kemmet Dental Design, I attempted to obtain the patient's (or representatives) signature on this acknowledgement but did not because:

_____ I could not communicate with the patient due to _____
_____ The patient refused to sign
_____ The patient was unable to sign because _____
_____ Other_____

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DENTAL INSURANCE:

Policy Holder_____Relationship to Patient_____

Employer_____

Insurance Company_____SSN and DOB of Policy Holder_____

Insurance Company Address _____

Insurance Phone Number_____ID#_____Group #_____

I authorize Kemmet Dental Design to release information as needed to my insurance company, including but not limited to: diagnosis, records of treatment provided or any examination received. I authorize my insurance company to pay my dental benefits directly to Kemmet Dental Design. I understand that dental insurance is a contract between myself and my insurance company and that any lapse in insurance coverage will result in sole responsibility and full payment of dental services rendered. I understand that my insurance benefits may pay less than the actual charge for services. I acknowledge that I am responsible for any portion of treatment not covered by my insurance company for myself and/or my dependants.

X_____Date_____
(Signature of Patient or Guardian if Minor)

GENERAL EXAMINATION INFORMED CONSENT:

1. **Examination and X-rays:** I understand that my initial visit will require certain radiographs in order to complete my examination, diagnosis and treatment plan.
2. **Temporomandibular Joint Dysfunctions (TMJ):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower subsequent to routine dental treatment wherein the mouth is held in an open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist, and the cost of which is my responsibility.

Consent: *I understand that dentistry is not an exact science, therefore: our practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist other than the treating dentist is responsible for my dental treatment.*

X_____Date_____
(Signature of Patient or Guardian if Minor)

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FINANCIAL POLICY:

INSURANCE: Your dental insurance is ultimately your responsibility. We attempt to estimate your insurance benefits and co-pay fees closely, but these estimates are not guaranteed. You are responsible for the total treatment fee. The outlined estimate is based on limited information obtained from your insurance company. We allow 60 days for your insurance company to make a payment, after this time all inquiries (follow-up) on payments due from your insurance become your responsibility.

NO INSURANCE: I do not currently have dental insurance benefits; I agree to pay the full amount due for all completed services prior to or on the day of my appointment, unless other payment plans are agreed to before service.

All remaining balances due to Kemmet Dental Design are subject to:

- A non-payment fee of $35 per ALL monthly statements
- A service fee of 18% APR on any statement over 25 days after the service was performed

Any account not settled within 90 days from the date of service will be subject to:

- 3rd party collections agency and credit monitoring service reporting
- Court costs, attorney fees, and collection fees
- Possible dismissal as a patient of Kemmet Dental Design

CANCELLATIONS: Kemmet Dental Design values you as a patient and as such, we reserve your appointments in advance. We ask for at least 48 hours notice on any appointment that you are unable to keep. If a consistent pattern of cancelling within 48 hours or not showing up for scheduled appointments is observed, any and all future appointments will be subject to a reservation fee of $100/hour of appointment time. This reservation fee is non-refundable if the appointment is cancelled within 48 hours or upon failure to show for the scheduled appointment. Furthermore, if a pattern of consistency is observed, such as two failed appointments in 6 months, you may be dismissed as a patient.

X_____Date_____

(Signature of Patient or Guardian if Minor)

Time 8:32 AM | Kemmet Dental Design | Date 11/27/2018

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

Pregnant/Trying to get pregnant? | Nursing? | Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin | Penicillin | Codeine | Acrylic

Metal | Latex | Sulfa Drugs | Local Anesthetics

Other? | If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed above? Yes No | If yes

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:

X Date:_____