Today's Date: _____

Patient Name: _____ I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____/_____/_____ Age: _____ Social Security #: _____ ☐Single ☐Married ☐Divorced ☐Widowed ☐Child

Home Address: _____
STREET CITY STATE ZIP

Home Phone #: (_____)_____ Cell #: (_____)_____ Work #: (_____)_____ Driver Lic. #: _____

Email Address: _____ **How did you hear about us?** _____

Employer: _____ How long? _____ Occupation: _____

Employer's Address: _____
STREET CITY STATE ZIP

Person Responsible for Account (if other than yourself)

Name: _____Relation: _____ Phone #: (_____)_____ Social Security #: _____

Billing Address: _____
STREET CITY STATE ZIP

Work Phone: (_____)_____ Drivers Licence #: _____

Payment Method: ☐ Cash ☐ Check ☐ Credit Card: _____ _____/_____
Credit Card # Expiration

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance no paid by my insurance company (if offered at this office).
Initials

Insurance Information

Primary Insurance Medical Coverage? ☐Yes ☐No Dental Coverage? ☐Yes ☐No Orthodontic Coverage? ☐Yes ☐No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
STREET CITY STATE ZIP

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/____ Relation: _____

Insured's Employer: _____ Employers Address: _____
STREET CITY STATE ZIP

Emergency Contact

In the event of emergency, whom should we contact?_____Relation:_____

Home Phone #: (_____)_____ Work Phone #: (_____)_____ Cell Phone #: (_____)_____

Who is your Medical Doctor? _____ Medical Doctor's Phone #: (_____)_____

Patient Acknowledgement

I acknowledge that I have received and reviewed the summary of the Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that Justin D. Kiggins, D.M.D. is not always required to agree to the restrictions I request. I also understand that I may request and obtain a full copy of the Notice of Privacy.

Patient Name: _____

_____ _____
Signature of Patient or Legal Representative Date

Today's Date: _____ Patient Name:_____

MEDICAL HISTORY

Your current physical health is: ☐Good ☐Fair ☐Poor

Are you currently under the care of a physician? ☐Yes ☐No If yes, explain: _____

Do you **smoke** or use tobacco in any other form? ☐Yes ☐No If yes, how much per day? _____

Are you **allergic** to any of the following?

Y N	Aspirin	Y N	Barbiturates	Y N	Codeine	Y N	Erythromycin
Y N	Dental Anesthetics	Y N	Jewelry/Metals	Y N	Latex	Y N	Penicillin
Y N	Sedatives	Y N	Sulfa Drugs	Y N	Tetracycline	Y N	Other

Please list any additional drugs/materials that cause allergic reactions: _____

For **women:**

Are you taking Birth Control pills? ☐Yes ☐No

Are you pregnant? ☐Unsure ☐No ☐Yes/How long?_____ Are you nursing? ☐Yes ☐No

Have you ever taken (or are you ***currently taking***) any of the following?

Y N	Acetaminophen	Y N	Blood Thinners	Y N	Insulin/Diabetes Drugs	Y N	Steroids/Cortisone
Y N	Alendronate (fosomax)	Y N	Blood Pressure Medication	Y N	Ibandronate (Boniva)	Y N	Tiludronate (Skelid)
Y N	Antibiotics	Y N	Cold Remedies	Y N	Nitroglycerin	Y N	Thyroid Medicine
Y N	Antihistamines	Y N	Digitalis/Heart Medication	Y N	Pamidronate (Aredia)	Y N	Tranquilizers
Y N	Aspirin	Y N	Etidroname Disodium (Vidronel)	Y N	Recreational Drugs	Y N	Zolidronic Acid(Zometa)
Y N	Bisphosphonate			Y N	Risedronate (Actonel)		

Are you taking any prescription/over-the-counter-drugs not listed above? ☐Yes ☐ No

Please list any medications you are currently taking: _____

_____

Have you ever had head or neck radiation? ☐Yes ☐No

Do you or have you ever experienced the following?

Y N	Abnormal Bleeding	Y N	Colitis	Y N	Heart Attack	Y N	Liver Disease	Y N	Sickle Cell Disease
Y N	Alcohol Abuse	Y N	Congenital Heart Defect	Y N	Heart Murmur	Y N	Lupus	Y N	Sinus Problems
Y N	Anemia	Y N	Diabetes	Y N	Heart Surgery	Y N	Mitral valve Prolapse	Y N	Steroid Therapy
Y N	Arthritis	Y N	Difficulty Breathing	Y N	Hemophilia	Y N	Pacemaker	Y N	Stroke
Y N	Artificial Bones/ Joints	Y N	Drug Abuse	Y N	Hepatitis	Y N	Persistent Cough	Y N	Thyroid Problems
		Y N	Emphysema	Y N	Herpes	Y N	Psychiatric Problems	Y N	Tonsillitis
Y N	Asthma	Y N	Epilepsy	Y N	High Blood Pressure	Y N	Radiation Treatment	Y N	Tuberculosis (TB)
Y N	Blood Transfusion	Y N	Fainting Spells	Y N	HIV+ / AIDS	Y N	Rheumatic Fever	Y N	Ulcers
Y N	Cancer	Y N	Glaucoma	Y N	Kidney Problems	Y N	Scarlet Fever	Y N	STD/ Venereal Disease
Y N	Chemotherapy	Y N	Hay Fever	Y N	Hospitalized for Any Reason	Y N	Seizures		
Y N	Chicken Pox	Y N	Headaches			Y N	Shingles		

Other (please list): _____

DENTAL HISTORY

Why have you come to the dentist today?_____

Are you currently in pain? ☐Yes ☐No Please rate your pain on a scale from 1-10 with 1 being little pain and 10 being unbearable: _____

Previous/Present Dentist:_____ City:_____ State:_____ Phone: (_____)_____

When was your last: cleaning?_____ oral cancer test?_____

Why did you leave your previous dentist: _____

What did you like most/least about any dentist you have seen?_____

Y N Do you require antibiotics before treatments?
Y N Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ / TMD)?
Y N Do you have headaches, ear aches, neck or jaw pain?
Y N Do you floss daily?
Y N Do you brush daily?
Y N Do you use anything in addition to floss? If yes, what?_____
Y N Have you ever suffered from extreme dry mouth?
Y N Do you still have wisdom teeth?

Y N Do your gums ever bleed, get swollen or irritated?
Y N Have you ever had periodontal disease?
Y N Do you have loose, shifting or tipped teeth?
Y N Do you have any teeth or fillings broken?
Y N Are your teeth sensitive to heat, cold, or anything else?
Y N Do you have mouth ulcers or cold sores?
Y N Do you have bad breath?
Y N Have you ever had dentures or partials?
Y N Have you ever had braces?
Y N Have you ever had gum treatment?

Are you happy with the way your smile looks? _____ **Please rate your smile on a scale of 1-10 with 10 being the best** _____
If I could change my smile, I would:

Y N Whiten teeth
Y N Make teeth straighter
Y N Close spaces between teeth
Y N Repair chipped teeth

Y N Replace missing tooth
Y N Have a smile makeover
Y N Replace metal fillings with tooth colored ones
Y N Replace old crowns that don't match

On a scale of 1-10, with 10 being the highest rating:
How important is dental health to you (1-10)? _____ How would you rate your current dental health (1-10)? _____

Kiggins Family Dentistry - Courtesy Billing
Our office requires at least 24 hour notice prior to an appointment Cancellation or Change.

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

As a courtesy to you, we will verify your insurance benefits, file all of your dental claims, inform you when your insurance company has neglected to pay the estimated amount and we will file an appeal on your behalf when necessary.

You will be responsible for paying your co-payments and deductibles at the time of service, paying any remaining balance after insurance payments are received, providing us with the most current insurance information, and being aware of your dental benefits and coverage. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I have read and understand the conditions of the Courtesy Billing Options above. I certify that I am covered by _____ Insurance Co. and I assign directly to Kiggins Family Dentistry all insurance benefits. I understand that I am responsible for payment of services rendered, and also responsible for paying any co-payments and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform Kiggins Family Dentistry of any changes to the information I have provided.

_____ Print Name

_____ Signature of Patient or Legal Representative

_____ Date