



Today's Date: _____

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

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

Home Address: _____

Home Phone #: (____) _____^{Street} Cell #: (____) _____^{City} Work #: (____) _____^{State} Driver Lic. #: _____

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

Employer: _____ Occupation: _____

Employer's Address: _____
_____^{Street} _____^{City} _____^{State} _____^{ZIP}

Insurance Information

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

Insurance Co. Address: _____

Insured's name: _____ Insured's Social Security #: _____ Insured's Birthdate: ____ / ____ / ____

Insured's Employer: _____ Relation: _____

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 #: (____) _____

Kiggins Family Dentistry – Courtesy Billing

Our office requires at least a 24 hours 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



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 Barbituates	Y N Codeine	Y N Erythromycin
Y N Dental Anesthetics	Y N Jewelry/Metal	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 Cold Remedies	Y N Recreational Drugs	Y N Alendronate (fosomax)
Y N Antibiotics	Y N Digitalis/Heart meds	Y N Steroids/Cortisone	Y N Blood Pressure meds
Y N Antihistamines	Y N Ibandronate (Boniva)	Y N Tiludronate (Skelid)	Y N Etidronate Disodium (Vidronel)
Y N Aspirin	Y N Insulin/Diabetes meds	Y N Thyroid Meds	Y N Risedronate (Actonel)
Y N Bisphosphonate	Y N Nitroglycerin	Y N Tranquilizers	
Y N Blood Thinners	Y N Pamidronate (Aredia)	Y N Zolironic Acid (Zometa)	

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

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 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 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 Have you ever had gum treatment?

Y N Have you ever had braces?

Y N Have you ever had dentures or partials?

Y N Do you have bad breath?

Y N Do you have mouth ulcers or cold sores?

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?

Patient Acknowledgement

I acknowledge that I have the ability to request 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/Legal Representative

Date