Dr. Ryan Kay
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Patient Information

Patient Name: *«LName»,* *«FName»* *«MI»* *(«PrefName»)* Date: _____
Last, First MI (Preferred Name)

Social Security #: *«SS»* Birth Date: *«BirthDate»*

Phone (Home): *«HPhone»* (Work): *«WPhone»* Ext: *«WExt»* Email address: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: *«Street»* *«Street2»*
Street Apartment #

«City» *«State»* *«Zip»*
City State Zip Code

Health Information

Date of Last Dental Visit: *«LastVisit»* Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ HIV/AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bisphosphonates
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ _____
- ☐ _____

Current Medications (Include history of Bisphosphonates also**):** _____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____

*Name and phone number of person to contact in case of an emergency: _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date _____

Ryan Kay, D.M.D., Dentist Acknowledgement of Baseline Medical History & Review

Referral Information

Whom may we thank for referring you to our practice? «RefBy_Title» «RefBy_FName» «RefBy_MI» «RefBy_Name»

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: *«Guar_LName», «Guar_FName»*

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apt. #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: *«Emp_Name»* Occupation: _____

Address: *«Emp_Add1»* *«Emp_Street2»* *«Emp_Add2»* *«Emp_Phone»*

Street

_____

City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: *«PIns_Name»*

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand

Initials I am solely responsible for any balance not paid by my insurance company.

Consent for Services

The undersigned hereby authorizes Dr. Kay to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Kay to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Dr. Kay choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

In order to provide you with the highest quality of affordable dental care, we request that you pay for services rendered at the conclusion of each visit. Please remember that insurance is considered a method of reimbursing the patient for fees paid the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures while others pay a percentage of the charge. It is your responsibility to pay any co-insurance or any other balance not paid by your insurance. ***If your insurance payment is not received within 60 days, you will be responsible for your balance and we will issue a refund immediately when received***.

I understand that 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. *I further understand that a 1 ½ % finance charge (18% annually) will be added to any balance over 60 days*. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party