Keelan Dental

264 New Castle Road • Butler, PA 16001 (724)285-4153

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Insurance Subscriber or Parent/Guardian Information:

This only needs to be filled out if insurance subscriber is other than patient, or if patient is under 18.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

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

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ AIDS
- ☐ Alcohol/ Drug Use
- ☐ Aller. - Codeine
- ☐ Aller. - doxycycline
- ☐ Aller. - Iodine
- ☐ Aller. - Penicillin
- ☐ Aller. -"novocaine"
- ☐ Aller. -Aspirin
- ☐ Aller. -Ceclor
- ☐ Aller. -erythromycin
- ☐ Aller. -Keflex
- ☐ Aller. -Sulfa
- ☐ Aller. -Tetracycline
- ☐ Allergies Other
- ☐ Allergy, Latex
- ☐ Anemia
- ☐ Anesth -- no epineph
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Blood Thinners
- ☐ Cancer - Melanoma
- ☐ Cancer/existing
- ☐ Cancer/treated
- ☐ Cholesterol
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/siezure
- ☐ Glaucoma
- ☐ Gout
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High/Low Blood Press
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lumps in mouth
- ☐ Mental Disorders
- ☐ Mitral-valv prolapse
- ☐ Multiple Sclerosis
- ☐ Nervous Disorders
- ☐ Other Med Condition
- ☐ Pacemaker
- ☐ Premedicate
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ STI,STD,HPV
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers-Stomach
- ☐ Venereal Disease

- ☐ Ever been hospitalized (illness or injury)
- ☐ Presently being treated for any other illnesses
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Taking dietary supplements
- ☐ Subject to frequent headaches
- ☐ A smoker or smoked previously
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant

Do you take antibiotic premedication for your dental visits? If yes, please explain.

An allergic reaction to:

- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Acetaminophen
- ☐ Codeine
- ☐ Penicillin
- ☐ Erythromycin
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Local Anesthetic
- ☐ Fluoride
- ☐ Metals
- ☐ Latex
- ☐ Iodine
- ☐ Ceclor
- ☐ Doxycycline
- ☐ Keflex
- ☐ Other

If any conditions or alerts selected above needs further clarification, please describe below:

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name and Phone Number of Physician and Specialty:

Most recent physical exam and purpose:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

List all medications, supplements, and/or vitamins taken within the last two years:

☐ * **By checking this box, I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long have you been a patient there:

_____

_____

Date of most recent dental exam: _____

Date of most recent dental x-rays: _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience ☐ Had complications from past dental treatment ☐ Had trouble getting numb

☐ Had any reactions to local anesthetic ☐ Had/have braces, orthodontic treatment ☐ Had your bite adjusted

☐ Had any teeth removed

Smile Characteristics, Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?

☐ Have you ever whitened (bleached) your teeth?

☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?

☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

☐ You have problems with your jaw joint

☐ You have any problems chewing

☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn

☐ Your teeth crowding or developing spaces

☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits

☐ You clench you teeth in the daytime or make them sore

☐ You have problems with sleep or wake up with an awareness of your teeth

☐ You wear or have worn a bite appliance

Tooth structure, Check all that apply:

☐ Cavities within past 3 years

☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food

☐ You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth

☐ Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth

☐ Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling

☐ Food gets caught between any teeth

Gum and Bone, Check all that apply:

- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] History of periodontal disease in your family
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- [ ] Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. Keelan Dental will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, Keelan Dental cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimated for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services and/or my coinsurance at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to make contact by telephone to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the administration form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I acknowledge that I have the right to authorize access and disclosure of my protected health information (PHI) to anyone of my choosing for billing, condition, treatment, and prognosis to the following individuals:

Name:

_____

_____

Relationship:

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Communications

I grant my permission to Keelan Dental to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured database for the dental practice.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I grant my permission that Keelan Dental has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information to the secure database.

I have read the information above regarding the secured uploading of patient information to the secure database for Keelan Dental, and grant Keelan Dental permission to securely upload my patient information to the secure database.

☐ I do not wish to receive phone calls or voicemail.

☐ I do not wish to receive text messages.

☐ I do not wish to receive emails.

Response Date: ____/____/_____