MEDICAL HISTORY

John E. Kiesselbach, D.D.S., Inc. 6000 Fairway Drive Suite #10 Rocklin, California 95677

Patient's Name:__________________________________ Today's date:____________

Write your Dentist's full name: ______________________________

Age:____ Height:____ Weight:_____

Can you take/**PENICILLIN**? Yes ☐ No ☐ **CODEINE**? Yes ☐ No ☐ **TYLENOL**? Yes ☐ No ☐ **ASPIRIN**? Yes ☐ No ☐

What is your general health? _______ Do you **Smoke**? Yes ☐ No ☐ Do you drink **Alcohol**? Yes ☐ No ☐ How Much? ____

List any previous surgeries:____

List any medications you take regularly:____

Who referred you to this office?________________________________

What are you allergic to?____

Serious Illnesses/ Injuries: ____

Any complications with previous anesthetic experience?____

DO YOU HAVE ANY OF THE FOLLOWING: Please √

- Bleeding problems? Yes ☐ No ☐
- Nose or throat problems? Yes ☐ No ☐
- Cough: acute? Yes ☐ No ☐ or chronic? Yes ☐ No ☐
- Shortness of breath? Yes ☐ No ☐
- Asthma? Yes ☐ No ☐
- Bad drug reactions?Yes ☐ No ☐ What kind? ___________________

Other heart conditions? __________________

HAVE YOU TAKEN ANTIBIOTICS BEFORE DENTAL APPOINTMENT? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Your Physician Name: ___________________________

Physician's Telephone:_______________________

Do you or have you taken: Please √

Yes	No	
☐	☐	Phen-fen
☐	☐	Fosamax (Bisphosphanates)
☐	☐	Latex Allergy

Any other conditions I should know about?

____

HAVE YOU EVER HAD: Please √

YES	NO	
☐	☐	High Blood Pressure?
☐	☐	Cancer?
☐	☐	Seizures? When?
☐	☐	Rheumatic Fever?
☐	☐	Steroid Therapy? When?
☐	☐	Heart Disease?
☐	☐	Heart Murmur?
☐	☐	Radiation Treatment?
☐	☐	Swelling Ankles?
☐	☐	Hepatitis? A ☐ B ☐ C ☐
☐	☐	Emphysema? ☐ or TB? ☐
☐	☐	Psychiatric treatment?
☐	☐	Diabetes?
☐	☐	Porphyria?
☐	☐	Stroke?
☐	☐	Hemophilia or Bleeding disease?
☐	☐	Anemia?
☐	☐	Liver or Kidney disease?
☐	☐	Venereal disease?
☐	☐	Lung disease?
☐	☐	Aids or HIV?

If yes to any the above, please explain;

____

Signature of person completing this form: ____________________________

____
John E. Kiesselbach D.D.S.

Patients having a general anesthetic during surgery:
I have had nothing to eat or drink in the last 6 (six) hours.____

Signature Date

Account#___________________________ John E. Kiesselbach D.D.D., Inc.

PATIENT REGISTRATION FORM

Patient's Name: ___________________________________ Today's Date: ___/___/___

Date of Birth: ___/___/___ Social Security Number: _______-_______-_________

Address: ____

City:_________________________ State:_________ Zip:______________

Phone No. Home: (___)_____-_________Work: (___)____-_________ Ext:______

Cell: (___)____-________ Your Occupation:____________________________

Relationship to person responsible for payment: Self□; Spouse□; Child□; Other□

PERSON RESPONSIBLE FOR PAYMENT:

Mother's Name: ______________________

Dob: ___/___/____ SSN: ____-____-_____

Address: ______________________________

City: ___________ State: _____ Zip:______

Phone No. Home: ____________________

Work: ______________________________

Cell: ______________________________

Father's Name: ___________________________

Dob: ___/___/____ SSN: ____-____-_______

Address (if different): ______________________

City:______________State:____ Zip:________

Phone No. Home: _________________________

Work: ___________________________________

Cell: ___________________________________

Please provide a copy of your insurance card or cards.

Primary Dental Insurance Co: ______________________________ Group No: ________

Subscriber/member name: ________________________________ Date of Birth: __/__/__

Social Security No./ID# _________________________Insurance Phone:______________

Insurance Address: ____

Secondary Dental Insurance Co: ____________________________Group No: ________

Subscriber/member name: ________________________________ Date of Birth: __/__/__

Social Security No./ID# _________________________Insurance Phone:______________

Insurance Address: ____

Third Dental Insurance Co: ____________________________Group No: ____________

Subscriber/member name: ________________________________ Date of Birth: __/__/__

Social Security No./ID# _________________________Insurance Phone:______________

Insurance Address: ____

(If Applicable)

Medical Insurance Co: _______________________________ Group No: ____________

Subscriber/member name: _____________________________ Date of Birth:___/___/___

Social Security No./ ID#: __________________________Insurance Phone: ___________

Insurance Address: ____

I understand that I am responsible for paying all fees for treatment rendered. I understand that my insurance may only pay part of these fees. I understand that no contract exists between my insurance company and the Doctor. **Payment or insurance co-payment is to be rendered when services is provided.**

Signature of person responsible for payment: _____________________________

DENTAL INSURANCE

PAYMENT FOR SERVICES

At least partial reimbursement for dental treatment is often available through various dental insurance benefit plans. However, the treatment fee is your responsibility. You are responsible for any balance your insurance does not pay. Before treatment, read your dental and/or medical insurance
policy or check with your insurance representative concerning your coverage. Your dentist's office has its own financial policies, so be sure to discuss payment arrangements prior to your dental appointment and make sure all parties fully understand these arrangements.
The office's financial coordinator will be happy to answer any questions you have about fees and payment.

Sign:________________________________Date:___/___/___

Patient Consent Form: Use and Disclosure of Health Information Protected under HIPAA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of this facility.

I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations.

Further, I give my consent for the use of mail or e-mail to designated locations, including my home, to assist the organization in carrying out the described activities Treatment, Payment, and Healthcare Operations.

I hereby consent to the use and disclosure of my Protected Health Information (PHI) for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to extent that disclosures have been made in reliance upon my prior consent.

I hereby consent that photographs may be taken during my surgery to be used in a manner for medical programs developed on behalf of John E. Kiesselbach, DDS, Inc. I give my permission for these photographs to be used for educational purposes. I understand that my name will not be published on any of these materials beyond documentation for my chart.

Services are provided without regard of sex, race, color, religion, national origin, or disability.

Date: ________________ Patient Name: ______________________________

Patient Signature: __________________________

If applicable, Legal Guardian: ___________________________________

Copy: Patient, Patient's medical record

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