KITTRELL
FAMILY DENTISTRY

Matthew Kittrell, D.D.S. • 2600 Grove Ave • Richmond, Virginia 23220
(804) 359-6471

Patient Information Form

Demographics:

Name: _____ Date of Birth: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell:_____ Work Phone:_____

Soc. Sec. #:_____ Email:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Separated

Emergency Contact:

Name: _____ Relationship:_____

Cell Phone:_____

Responsible Party

Name:_____ Relationship:_____

Date of Birth:_____ Soc. Sec #:_____ Cell:_____

Address: _____ City: _____ State:_____ Zip:_____

Notice of Privacy Practices: Per HIPAA law, all patients must be provided a Notice of Privacy Practices. This document explains how our office uses and discloses your (PHI) protected health information. Please sign to acknowledge receipt of this notice. A readable or printed copy is available upon your request .

Signature:_____Date:_____

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MEDICAL HISTORY

Patient Name:_____ **DOB:**_____

Medication Allergies: ❒ Aspirin ❒ Codeine ❒ Latex ❒ Local Anesthetic

❒ Penicillin ❒ Sulfa ❒Other:_____

Please select the following that apply or have applied to you:

❒ Abnormal (High/Low) Blood Pressure
❒ AIDS/HIV
❒ Anemia / Bleeding Problems
❒ Artificial Heart Valves
❒ Blood Disease
❒ Congenital Heart Lesions
❒ Heart Problems
❒ Pacemaker
❒ Arthritis / Rheumatism / Gout
❒ Artificial Joints / Bones
❒ Asthma
❒ Cancer
❒ Chemotherapy
❒ Diabetes
❒ Emphysema
❒ Glaucoma
❒ Radiation Treatment (Xray/Cobalt)
❒ Shortness of Breath (Breathing Problems)
❒ Sinus Trouble
❒ Stroke / Thyroid Problems
❒ Tuberculosis
❒ Tumor / growth on head / neck
❒ Ulcer
❒ Epilepsy
❒ Fainting / Dizziness
❒ Headaches (Frequent)
❒ Hepatitis
❒ Herpes
❒ Kidney Disease
❒ Liver Disease
❒ Nervous Problems
❒ Psychiatric Care

Notice to Patients:

If you have had a joint replacement or heart surgery or certain cardiac issues you may require antibiotic premedication prior to dental procedures. Premedication is necessary to avoid a serious bacterial infection including sepsis. Please provide the name and phone number of your Orthopedic surgeon or Cardiologist so that we may obtain documented advisement regarding this requirement.

Date of Surgery:_____

Doctor's Name:_____ Phone_____

>>>>>>>Continued on Back >>>>>>>

❒ **List any other medical issues you have:** _____

❒ **List any serious Illnesses / surgeries / hospitalizations:** _____

❒ **Are you taking any medications?** _____

❒ **Do you Smoke?**_____ ❒ **Do you drink Alcohol?**_____❒ **High Sugar intake?**_____

❒ **Pregnant** ❒ **Nursing**

❒ **Has the patient ever been hospitalized?**

_____

❒ **Is the patient physically, mentally or emotionally impaired?**

_____

❒ **Is the patient under the care of a physician? Please list name and phone number:**

_____

Describe the patient's current physical health: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Any other concerns you would like us to be aware of?_____

Signature:_____ **Date** _____

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DENTAL HISTORY

Is the patient a minor? **YES or NO**

Is this your child's first dentist visit? **YES or NO**

Please provide the following dental provider details:

Previous Dentist Name:_____ Phone:_____

Do you (or your child) have any of the following??

Cavities / Decay	**YES or NO**	Mouth Breathing	**YES or NO**
Lip Sucking / Biting	**YES or NO**	Tongue Thrust	**YES or NO**
Speech Problems	**YES or NO**	Nursing / Bottle Habits	**YES or NO**
Nail Biting	**YES or NO**	Jaw Problems	**YES or NO**
Pacifier / Thumb / Finger Sucking	**YES or NO**	Grinding Teeth	**YES or NO**

Has the patient ever had orthodontic treatment (Braces)? **YES or NO**

Has the patient ever had any pain/tenderness in their jaw joint (TMJ/TMD)? **YES or NO**

Reason for visit:_____

Date of last dental visit: _____Date of last dental X-rays:_____

How often do you floss?: Everyday Often Rarely Never

How often do you brush?: Twice per day Once per day Not Everyday

Bad Breath: Never Occasionally Constantly

Bleeding, Red or Swollen Gums? **YES or NO**

Broken/Loose teeth or fillings: **YES or NO**

Clicking or popping jaw: **YES or NO**

Grinding teeth: **YES or NO**

Pain around ear/side of face: **YES or NO**

Sores/Blisters in mouth: **YES or NO**

List any other dental concerns/pain:_____

_____

_____

What did you like the most about your previous dental office?:_____

_____

What did you like the least about your previous dental office? _____

_____

Are you interested in whitening your smile? _____

Are you happy with your smile? If not, what would you change? _____

_____

Signature:_____Date:_____

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Surgeon's Name:_____

Name of Medical Practice: _____

Contact Phone: _____

Please sign below to acknowledge receipt of this notice:

Signature:_____Date:_____

KITTRELL FAMILY & COSMETIC DENTISTRY - CVDC
PRACTICE FINANCIAL POLICY

ALL charges for dental services rendered are the direct financial responsibility of the patient or an assigned representative (ie: a parent), even if the patient carries dental insurance.

- We acquire your dental insurance and file claims with your carrier as a courtesy to you.
- We will apply our best efforts, based on the information provided by your insurance plan, to provide your coverage information and estimates for services.
- **ALL** insurance plans have a disclaimer that benefits and coverage are never guaranteed. A final determination is not made until the claim has been processed.
- It is **YOUR** responsibility to provide us with your current insurance information in order to accurately process claims.
- It is **YOUR** responsibility to understand your dental insurance coverage. This includes any requirements, frequencies, limitations and maximums.
- Fee estimates for dental care can only be extended for a period of six (6) months from date of consultation.
- Payment for services is due at the **time of treatment,** or if billed by this office, payment is due within thirty (30) days of billing. Any accounts delinquent for ninety (90) days or more will be subject to escalation of the account to a collection agency.
- Charges for services shall be as billed unless disputed by the patient, in writing by the time the payment is due.
- The practice depends on reimbursement from patients for the costs incurred in their care.
- Should your account require submission to collections, we assess a 15% administration fee.
- By signing below I acknowledge that I understand and agree to the above information.

SIGN:_____ DATE:_____