



Patient Information

Name: _____ Title: Mr/Mrs/Other _____ Nickname: _____ Circle: Male Female

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

Social Security # _____ Date of Birth: _____

Required for us to file your insurance

Phone: Home# _____ Cell# _____ Work# _____ E-mail _____

May we leave a message? Y___N___ May we release information to immediate family members? Y___N___

Emergency Contact Name: _____ Relationship: _____ Phone _____

Family Physician: _____ Dr. Ph #: _____

Employer: _____ Employer Ph # _____

Employer Address: _____

If new to our office: Where were you last seen? _____ Whom may we thank for referring you? _____

Responsible Party Information If other than patient, send statement/bill to:

Name: _____ Title: Mr/Mrs/Other _____ Relationship to patient: _____

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

Phone: Home# _____ Cell# _____ Work# _____ E-mail _____

Social Security # _____ Date of Birth: _____

Required for us to file your insurance

Employer: _____ Employer Ph # _____

Name _____ City _____

Dental Insurance Information

Primary: _____

Secondary: _____

Policy # _____ Grp # _____

Policy # _____ Grp # _____

Insured Name: _____ DOB _____

Insured Name: _____ DOB _____

Relationship to Patient _____

Relationship to Patient _____

Authorization and Consent for Services

We are a fee for service office, payment is due at the time of service. We accept cash, check, and credit card. We also have a flexible payment plan called Care Credit, information is available in our office.

If you are covered by insurance, your portion is due at time of treatment. An estimate of your portion is available from our office staff. As a courtesy, we will file your insurance for you within 24 hours of your visit. Some insurance policies restrict payment for some services. Please become familiar with your policy, ultimately you are responsible for treatment costs. If your insurance pays you directly, you are responsible for all charges at the time of service.

Accounts with balances more than 90 days overdue will receive notice of delinquent status. Failure to settle the account will result in third party collections.

A specific amount of time is reserved for your appointment. As a courtesy to our other patients, we kindly request two business days notice when rescheduling appointments. Failure to give proper notice will result in a \$60 late notice fee. If numerous appointments are missed, the patient will prepay or this may lead to dismissal from the practice.

Your privacy is very important to us. We may use or publish photographs for any lawful purposes. Our Notice of Privacy Practices is available on our website and in our office.

I acknowledge and authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate and the release of information including the diagnosis and records of treatment or examination for myself and my dependant(s) to third party insurance carriers, payors, and/or healthcare providers. I authorize my insurance carrier to submit payment directly to this office to be applied to any outstanding balance on my account.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge.

Signature of patient or responsible party

_____ if not patient, relationship to patient _____ Date _____

Patient Medical History

Name: _____

Are you pregnant? Y_____ N_____

Do you experience jaw pain? Headaches? Teeth grinding? Please Explain _____

Do you consider yourself to be in good health? Y_____ N_____ Do you use tobacco (smoking or chewing)? Y_____ N_____

***Within the last three years have you been in the hospital? Y_____ N_____

If yes, please explain _____

***Within the last three years have you stopped or started a medication? Y_____ N_____ Please be prepared to list your current medications.

***Do you take bone density medication? Y___ N___

Have you ever had complications following dental treatment? Y_____ N_____

If yes, please explain _____

Please indicate if you have had any of the following:

Abnormal Bleeding	Y___ N___	Asthma	Y___ N___	Cancer/Chemo/Radiation	Y___ N___
Congenital Heart Disease	Y___ N___	Congestive Heart Failure	Y___ N___	Emphysema	Y___ N___
Endocarditis	Y___ N___	Epilepsy/Seizure Disorder	Y___ N___	Heart Attack	Y___ N___
Heart Transplant	Y___ N___	Stroke	Y___ N___		
Artificial Joints or Valves Y___ N___ If yes, date of replacement _____					

Do you need to take pre med before a dental visit? Y_____ N_____

AIDS/HIV	Y___ N___	Blood Thinner	Y___ N___	Diabetes	Y___ N___
Epinephrine Sensitivity	Y___ N___	Heart Murmur	Y___ N___	Hepatitis	Y___ N___
High Blood Pressure	Y___ N___	Kidney Disease	Y___ N___	Liver Disease	Y___ N___
Low Blood Pressure	Y___ N___	Mitral Valve	Y___ N___	Osteoporosis	Y___ N___
Pacemaker	Y___ N___	Rheumatic Fever	Y___ N___	Tuberculosis	Y___ N___

Are you allergic to or have you had a reaction to:

Codeine	Y___ N___	Latex	Y___ N___	Local Anesthetics	Y___ N___
Penicillin	Y___ N___	Sulfa	Y___ N___		

Do you have any other conditions, diseases, allergies, etc., not listed that we should know about? Y___ N___

If yes, please explain _____

Are taking any medications? Y___ N___

If yes, please list here or provide us with a medication list.

I understand the above medical information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I understand that failure to update my health history has the potential of being hazardous to my health. I will notify the office of any changes in my health or medication. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

Signature of patient or responsible party

_____ if not patient, relationship to patient _____ Date _____



South Location
25947 CR 20
Elkhart, IN 46517

574-293-4213

North Location
902 CR 6 East
Elkhart, IN 46514

574-293-7032

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment, directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time, at the address above, to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Print Patient Name _____ Date _____

Patient Signature _____
(Parent or Guardian, if patient is minor)

I give authorization to release my protected health information to a family member or person of choice.

Name _____ Date _____

Relationship to patient _____

How would you prefer we reach you? Please check all that apply. Call _____ Text _____

E-mail _____ E-mail address _____

May we leave a detailed message at home? _____

May we leave a detailed message on your voicemail? _____

May we leave a detailed message with others? _____

*** For Minor Patients *** If you will be sending your minor child with someone else (i.e. grandparent/spouse/other adult), please list any person(s) we may share details about your child's care, including billing and insurance information.

Name _____ Phone Number _____

Name _____ Phone Number _____



Cancellation and Missed Appointment Policy

King Dental Group requires Two business days' notice to cancel an appointment to avoid a cancellation fee. At King Dental Group your health is important to us, which is why time has been set aside for your dental needs. We understand that there are times you must miss an appointment due to emergencies. We ask that you be courteous and communicate with us so your appointment time may be used by others in need.

Office appointments which are cancelled with less than Two business days' notice will be charged a fee of **\$60.00**. This fee is the sole responsibility of the patient and must be paid in full before the patient's next appointment. These fees are NOT covered by insurance. If numerous appointments have been missed the patient will be required to prepay for all future appointments or this could result in being dismissed from King Dental Group.

Please sign that you have read, understand and agree to this

Cancellation/Missed Appointment Policy

Patient Name: _____

Name of Person Signing (if Minor) _____

Patient/Representative Signature: _____

Date: _____