Kuhnel Dentistry

## NEW PATIENT INFORMATION

Last Name:_____ First:_____
Middle Name:_____ Preferred or Nickname:_____
Address:_____City_____State:_____ Zip Code:_____

Mailing Address:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
SS#:_____ Date of Birth:_____ Sex: **M** ☐ **F** ☐ Marital Status_____
Email Address:_____ How do you prefer to be contacted?_____
Patient Employer/School:_____ Who May We Thank for Referring You?_____
Emergency Contact:_____ Relationship:_____ Phone:_____

**PRIMARY INSURANCE COVERAGE (please provide your card for our records):**
Policy Holders Name: _____ SS# _____ Date of Birth_____
Relationship to Patient:_____ Member ID #_____ Group ID #_____
Insurance Company:_____ Employer Name_____

**SECONDARY INSURANCE COVERAGE (if applicable):**
Policy Holders Name: _____ SS# _____ Date of Birth_____
Relationship to Patient:_____ Member ID #_____ Group ID #_____
Insurance Company:_____ Employer Name_____

**Assignment and Release:** I certify that I, and/or my dependent(s), have insurance coverage with the above listed insurance company(ies) and assign directly to Dr. Cristina Kuhnel all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named dentist may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

**Patient Signature:_____Date:_____**


## MEDICAL HISTORY

Patient Name:_____ Do you smoke or use tobacco? ☐Yes ☐No

***If female***:

Are you taking Birth Control Pills? ☐Yes ☐No

Are you Pregnant? ☐Yes ☐No

Are you Nursing? ☐Yes ☐No

Do you have - or have you ever had - any of the following conditions and/or treatments? (Please check all that apply)

☐Abnormal Bleeding
☐Alcohol Abuse
☐Alzheimers
☐Anemia
☐Angina Pectoris
☐Arthritis/Rheumatism
☐AIDS/HIV
☐Artificial Heart Valve
☐Artificial Joints
☐Asthma
☐Back Problems
☐Blood Disease
☐Blood Transfusion
☐Cancer – Chemotherapy
☐Circulatory Problems
☐Chemical Dependency
☐Congenital Heart Lesions or Defects
☐Colitis
☐Cortisone Treatments
☐Diabetes
☐Difficulty Breathing
☐Drug Abuse
☐Emphysema
☐Epilepsy
☐Fainting or Dizziness
☐Frequent Headaches
☐Glaucoma
☐Heart Attack
☐Heart Disease
☐Heart Murmur
☐Heart Surgery
☐Hemophilia
☐Hepatitis Type _____
☐Herpes
☐High Blood Pressure
☐Jaundice
☐Jaw Pain
☐Kidney Disease
☐Liver Disease
☐Lupus
☐Mitral Valve Prolapse
☐Pacemaker
☐Psychiatric Problems
☐Rheumatic Fever
☐Scarlet Fever
☐Seizures
☐Shingles
☐Shortness of Breath
☐Sickle Cell Disease
☐Sinus Problems
☐Special Diet
☐Stroke
☐Swollen Neck Glands
☐Thyroid Problems
☐Tonsillitis
☐Tuberculosis
☐Ulcers
☐Venereal Disease

**Allergies**: (check all that apply)

☐NO KNOWN
☐Aspirin
☐Barbituates (sleeping pills)
☐Codeine
☐Dental Anesthesia
☐Erythromycin
☐Jewelry / Metals
☐Iodine
☐Latex
☐Penicillin
☐Sulfa
☐Tetracycline
☐Other:
_____

Please list any medications you are currently taking:
_____
_____
_____
_____

Are there any other diseases conditions or problems that we should be aware of that is not listed above? If so, Please describe:
_____
_____
_____

## Pharmacy Information:

**Name of Pharmacy:** **Phone Number:** **Location:**_____

**Emergency Contact:** **Relationship:** **Phone Number:**_____

**Patient Signature:**_____ **Date**:_____

Kuhnel Dentistry

## Kuhnel Dentistry Practice Policies

Our Primary Goal is for each patient to establish or maintain a **"Healthy Mouth"** through our excellent and efficient care. In an effort to keep our fees reasonable and to continue to provide quality care, we have established the following policies:

- **Payment is due at the time that the service is rendered.** Although we are happy to submit your insurance on your behalf as a courtesy, your insurance policy is not a guarantee of coverage. In addition, certain procedures may not be covered at all. There could also be deductibles and annual maximums that may apply.

- **All necessary dental treatment will be recommended.** In this case, a treatment plan will be presented to you, and it will include several different payment options. This will allow you to proceed with your needed treatment while still maintaining your lifestyle. All treatment must be paid in full upon completion of the treatment, and any appointments exceeding a value of $500 will require a deposit of 30%. In some cases, pre-payment may be required.

- **Outstanding balances are not permitted.** Before we can schedule any new services or appointments, payment for prior services must be collected. Any failure to pay in a timely fashion, may subject your account to finance charges.

- **We know that you have a busy schedule and we respect your time!** We request that you respect ours as well. We strive to see all of our patients on time; If you are late for your appointment, you may need to be rescheduled.

- **We do enforce a 48-hour cancellation policy**. Your appointment time has been set aside especially for you. If you are unable to keep your appointment we ask that you provide 48-hours notice in order to avoid the cancellation fee of $70.

By signing below, you acknowledge and agree to adhere to these policies.

Patient Signature Date