Registration Form For New Patient Of Kocher and Kocher Dentistry PA

First Name _____Last Name _____Preferred "Nickname" _____

Birthdate _____

Social Sec # _____

Gender _____

Marital Status (S/M) _____

Cell Phone # _____

Home Phone # _____

Work Phone # _____

Email _____

Referred to our office from??? _____

Preferred Method To Confirm Appointments (Circle One)

Text Message (**Recommended**) Cell Phone Call Email Home Phone Work Phone

Preferred Method Of Contact (Circle One)

Cell Phone Call (**Recommended**) Text Message Email Home Phone Work Phone

Primary Insurance

Relationship To Insured Party (Circle One) CHILD SPOUSE SELF (I am insured party)

Insurance Subscriber Full Name _____

Insurance Subscriber Full ID _____

Insurance Carrier Name _____ Insurance Carrier Phone Number _____

Insurance Employer Name _____

Insurance Group Name _____ Insurance Group Number _____

Secondary Insurance

Relationship To Insured Party (circle one) CHILD SPOUSE SELF (I am insured party)

Insurance Subscriber Full Name _____

Insurance Subscriber Full ID _____

Insurance Carrier Name _____ Insurance Carrier Phone Number _____

Insurance Employer Name _____

Insurance Group Name _____ Insurance Group Number _____

Signature _____

Date _____

Medical History Form For New Patient of Kocher and Kocher Dentistry

First Name _____ Last Name _____ Birthdate _____

List of Medications You Are Now Taking

_____ _____ _____ _____

_____ _____ _____ _____

Are you allergic to any of the following conditions?

(Answer All Questions Please)

Latex	YES	NO
Penicillin	YES	NO
Clindamycin	YES	NO
Metronidazole ("Flagyl")	YES	NO
Ibuprofen (Advil, Motrin)	YES	NO
Steroids (Medrol)	YES	NO
NSAIDS	YES	NO
Tylenol	YES	NO
Opioids	YES	NO
Benzodiazepines	YES	NO
Tramadol	YES	NO
Z-Pack	YES	NO

Do you have any of the following medical conditions?

(Answer All Questions Please)

Heart Condition	YES	NO
Diabetes	YES	NO
Pregnant	YES	NO
Metronidazole ("Flagyl")	YES	NO
Presently Have Cancer	YES	NO
NSAIDS	YES	NO
Hepatitis	YES	NO
Heart Attack or Stroke in Past 6 Months	YES	NO
Opioids	YES	NO
Blood Disorder Or Bleeding Problem	YES	NO
High Blood Pressure	YES	NO
Psychiatric Treatment	YES	NO
HIV or AIDS	YES	NO
Artificial Joint (Last 6 Months)	YES	NO
History Of Seizure	YES	NO
Smoke Cigarettes	YES	NO
Illicit Drug Use	YES	NO
Autoimmune Disorders	YES	NO
Organ Failure	YES	NO

Patient Signature _____

Date_____

Staff Signature _____

Date _____

Dental History Form For New Patient of Kocher and Kocher Dentistry

First Name _____ Last Name _____ Birthdate _____

What is the purpose of your visit today? _____

When were you last at the dentist? _____

When was the last time you had a teeth cleaning? _____

If you are having a problem with anything in your mouth, give a description here _____

_____

Do you have any special requests to make you more comfortable? _____

(Circle One; Answer All Questions Please)

Do you have any missing teeth?	YES	NO
Do you have crooked teeth or is your "bite off"?	YES	NO
Have you ever had braces or Invisalign before?	YES	NO
Have you been diagnosed with gum disease before?	YES	NO
Have you ever had “deep cleanings” before?	YES	NO
Do you have any broken or chipped teeth?	YES	NO
Do you have any loose teeth?	YES	NO
Do your gums ever bleed?	YES	NO
Are you nervous when you go to the dentist?	YES	NO
Are you unhappy with the appearance of your teeth?	YES	NO
Do you clench or grind your teeth day or night?	YES	NO
Does your jaw click or pop?	YES	NO
Do you have facial pain or jaw muscle pain?	YES	NO
Do you have sensitive teeth?	YES	NO
Do you brush your teeth twice per day?	YES	NO
Do you floss your teeth regularly?	YES	NO
Have you had problems with previous dental treatment	YES	NO

Patient Signature _____

Date_____

Staff Signature _____

Date_____

Office Policy For Insurance

If our office has a contract with your insurance provider, we follow a fee schedule dictated by them. It is your responsibility to understand your benefits, what services are 'covered', what the fees are and what your out of pocket costs will be, if any. However, we will help you do this prior to any services rendered in our office. We will estimate your copays or out-of-pocket expenses and inform you either verbally, in written form or both. We do this as a courtesy, as we have years of experience and are happy to share this with our patients. However, mistakes in our estimates can occur as a result of an oversight on our part, or, more commonly, a mistake in the information provided to us from you insurance company when we are obtaining your benefit information. You will be responsible for any unpaid insurance amounts as per our contract with your insurance company. This means our estimates for your benefits and out-of-pocket costs are estimates, and done in best faith, but are not exact and can be incorrect. If you have questions about potential out of pocket expenses that could arise, please ask prior to services rendered.

I have read, understand and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Kocher and Kocher Dentistry.

Signature _____

Date_____

HIPPA Privacy Disclosure

Patient First Name _____ Patient Last Name_____

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Other Persons With Permission Above

First Name _____ Last Name _____

Relationship _____

First Name _____ Last Name _____

Relationship _____

Patient Signature _____

Date _____