Stanley F. Kayes, DDS

PATIENT REGISTRATION FORM

Name____ Date of Birth_____________________________

Address____ City/State/Zip____________________________

Identification (driver's license or other government approved ID) ______________________________________

Employer/Occupation____

Spouse's Name_________________________________ Spouse's Employer_____________________________

Your primary medical provider(s)_________________________________ Telephone______________________
Person to Contact
In an Emergency_______________________________________ Telephone_____________________________

How did you find out about this office? ____

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INSURANCE INFORMATION

Name of Primary Insured____________________________ Insured's Birthdate___________________________

Ins. Company______________________ Certificate #____________________ Group #_____________________

Insurance Address____Phone__________________________

Secondary Dental Insurance Information
Name of Primary Insured__________________________________ Insured's Birthdate______________________

Ins. Company_____________________ Certificate #___________________ Group #______________________

Insurance Address____Phone__________________________

INSURANCE AUTHORIZATION AND RELEASE

I authorize the dentist to release information and records of any treatment rendered to me to my insurance company or to other health care providers, including my medical provider, any specialists to whom I am referred, laboratories, or hospitals __________(initial)

I authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me ______ (initial)

I understand that my dental insurance may pay less than the actual bill for service and that this office does not guarantee any payment from my insurance company. I understand that it is my responsibility to know my insurance company's regulations regarding the timing of my dental exam, x-rays, and cleaning appointments, and their rules regarding substitution of alternative dental treatments. I agree that I am responsible for payment to this office for any amount not covered by insurance_____(initial)

Signature____ **Date**________________________

For young adults over age 18 with parents responsible for account:
You may discuss my treatment with my parents________________
Person responsible for payment of my account_______________________________________ If parents are responsible at least in part for payment, please sign to authorize discussion of the account with them.

Signature____ **Date**________________________

FINANCIAL POLICY/ CANCELLATION POLICY

We care about you and your family and want you to understand policies for payment before beginning dental treatment. Below we have outlined our policy for fee payments. We can file your insurance claims for you, and we take major credit cards and can provide extended financing,

We provide estimates of your insurance benefits as a courtesy but we cannot guarantee any payment. Dental plans often do not cover all necessary services, and may pay less than expected for services that are covered. You are responsible for any amount that is not covered by your plan. You are also responsible for making sure that your coverage is in force for all family members and that all waiting periods have been met. If you have any concerns about your coverage, we advise you to call your insurance company before beginning treatment to check your benefits. We will be happy to help to explain anything that you may not understand regarding your benefits.

Payment of co-pays and deductibles are required at time of visit. For dental procedures requiring two or more visits, payment for procedure or deductible and copay is required at the first visit.

All checks returned by the bank are subject to a fee of $60.00.

In case of default of account for present and future balances, patient or person responsible for account agrees to pay collection costs, including attorney's fees, incurred in attempt to collect balance due.

Appointment cancellations and no shows: We will attempt to contact you to confirm appointments. If you cannot be contacted after several attempts to confirm appointment, the appointment time may be released to another patient on a waiting list. If after appointment confirmation is made, you do not show for the appointment or cancel with less than twenty-four hours notice, except for an emergency, a cancellation fee of $60.00 may be applied.

Signature____ **Date**____________________

Stanley F. Kayes, DDS

Medical History

Name____ Date________________

Personal Medical History
Please circle any that apply and explain below if necessary.

Heart Disease	Hepatitis	High Blood Pressure	Cancer	Chronic Headaches	Acid reflux
Heart Murmur	HIV Positive	Glaucoma	Diabetes	Head Injury	Bulimia
Mitrovalve Prolapse	AIDS	Liver Problems	Asthma	Stroke	Pregnancy
Rheumatic Fever	Herpes	Kidney Disease	Respiratory Problems	Jaw Injury	Allergies
Artificial Joints	Cold Sores	Thyroid Problems	Clotting Problems	Arthritis	
Organ Transplant	Tuberculosis	Epilepsy, Seizures	Anemia	Chronic Sinus Problems	
Iodine Allergy	Cholesterol	Osteoporosis			

Please explain any condition listed above or detail any other medical condition ________________________________

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List any allergies or drug reactions, including penicillin____

Past or present conditions relating to drug or alcohol use - Please check if you need to discuss this with us ________
Please note: If you have any present or past problems with alcohol or drugs, we do need you to tell us. This is kept confidential but is important for us to know since even past use can cause permanent changes to liver or kidney function. If organ damage has occurred it can cause serious medical consequences if certain dental anesthetics are used.

Family and Social Medical/Dental History
Is there a family history of heart disease, stroke, diabetes, or periodontal disease?______________________________
Do you have a close relationship or live with someone with periodontal disease or serious dental decay problems? ___________

Medication Review and Dry Mouth Screening (If you need more space, use back of form)
Please list all medications you are taking and the conditions you are taking them for

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Do you have any mouth burning sensation or gum tissue soreness? ________Do you have any bad taste in your mouth?________

Oral Cancer Risk Screening (Please check any that apply)
Smoker _____ Other tobacco use______ Tobacco use in the past______
Is your diet low in fruits or vegetables?____ Are you over forty?______ Have you noticed unusual spots in your mouth?________
How many times per week would you estimate you have one or more servings of beer, wine or other alcoholic beverage?_______

Chemical Acid Erosion Screening
How often do you consume beverages or foods that are sugary or acidic? This includes sodas, diet sodas, fruit drinks, juices, sports drinks, or any drinks with phosphoric or citric acid. Never_____ Once a week or less____ A few times a week_____Daily_____
Do you have any medical conditions that include problems with vomiting? ________

Screening for Cavities, Gum Disease, TMJ (Please check any that apply)
Do you have any tooth pain or sensitivity ?_______Do you have bleeding gums?_______
Have you had unexplained headaches, jaw, or facial pain?____________
Is your diet high in sugar?______ Are you taking any syrupy medications?_______
Do you consume dairy products daily or take a calcium supplement?______________
Is your water supply fluoridated?_______________

Dental Care History
Approximate date of last dental exam ____________ Approximate date of last x-rays ____________
Have you ever had any reaction to a dental anesthetic? Explain ____
Have you had any problems with dental care in the past? Explain ____

DENTAL CARE – WHAT WE WANT YOU TO KNOW

With recent research implicating dental disease as a risk factor for many life-threatening illnesses, we feel it is important for every patient to understand their dental health and possible consequences of neglecting dental care.

Preventive care, periodontal disease, and health risks: If hardened plaque (called calculus) is not removed at the dentist's office regularly, periodontal disease can develop, and **patients with periodontal disease may show double the risk of heart attacks and up to triple the risk of stroke when compared to those without the disease.** Your teeth should be examined and scaled every six months; if you have any periodontal problems, they should generally be scaled at three-month intervals. While we will try to help you remember when you are due for a cleaning, it is your responsibility to make sure that you do not neglect your continuing care.

Oral Cancer: Oral cancer is sixth most deadly form of cancer, primarily because lesions are not found at an early enough stage for successful treatment. If found early, the treatment has a 90% change of eliminating the cancer. We provide cancer screening at every recall visit and utilize advanced oral cancer screening methods that enable us to find lesions at an early stage. This test is generally not covered by insurance and will involve an extra cost to the patient. You have the right to refuse this test.

X-rays: We will be providing you with a risk assessment for dental disease, including cavities and periodontal disease, along with any risks related to your overall health. If you are at high risk, we may be taking x-rays of problem areas yearly until your risk is lowered.

Dental decay and periodontal disease are infections: Periodontal disease bacteria can enter the bloodstream, affecting your immune system, and causing increased risks of heart disease and stroke, as mentioned above. The bacteria that cause dental decay do not cause the systemic problems that periodontal bacteria may cause, but if decay is left untreated, an abscess can form and can spread to areas outside the mouth. This can be life threatening if the abscess spreads to the brain.

Anesthesia: We use local anesthesia for many dental procedures. Complications are rare, but could include soreness at the injection site, a reaction to epinephrine, or possible temporary stiffness or swelling at the injection site. If you have high blood pressure, glaucoma, have had past epinephrine reactions, or could be pregnant, you need to inform us before dental work is performed since those conditions require use of an anesthetic without epinephrine.

Filling materials: We use tooth colored composite for most fillings. Because the filling material is hardened before anesthesia wears off, there is a chance (about 4%) that an additional visit may be required for adjustment. Composite materials require a completely dry, saliva free field for a bond to form to the tooth. There is a chance (about 1%) that the filling may have to be redone if the bond does not form successfully.

I acknowledge discussion of the above topics and have been given an opportunity to ask questions.

Patient Signature____ **Date**____________________