NEW PATIENT INFORMATION SHEET

Date

Birth Date Age

Social Security Numer

Title Mr. Last Name First Name Middle Name

Home Phone Work Phone Cell Phone

Address

Street No Apt # City State Zip

Referred by

Have any family members been in this office before? Name.

Nearest relative other than above address, please notify: Name Phone

Address

Street No Apt # City State Zip

Person or Gaurdian Responsible for Paying Your Bills:

Address of Responsible Party:

Insurance Coverage: ID#

Group#:

Insured's Name Insured's SS# DOB

Insured's Employer Occupation Work Phone:

Spouse's Name SS# Ins Co.

Sp;ouse's Employer Occupation Work Phone:

I (we) have read the seven items below. I (we) understand and agree to all seven.

1. Authorization to pay benefits to Doctor : I hereby authorize payment directly to Jeffery A. Kohler, D.D.S. , P.C. , if any, payable to me for his service by my insurance policy.
2. Authorization to release information : I hereby authorize Jeffery A. Kohler, D.D.S. , P.C. to release any information acquired in the course of my examination and treatment to my insurance company.
3. I hereby authorize Jeffery A. Kohler, D.D.S. , P.C. to bill and to accept payment via a bank credit card.
4. I hereby agree to pay for services rendered to the abovementioned patient as and when charges are incurred. In the event of default I promise to pay legal interest on the indebtedness, together with such collection and reasonable attorney fees as may be required to affect collection of this note.
5. Method for Resolving Discomfort. All parties desire a method for resolving discomfort, misunderstandings, or disputes, if any should occur - privately, quickly, economically, and in a friendly, educational manner. We therefore agree to resolve these matters using the communication, negotiation, mediation, and arbitration procedures set forth in the latest edition of the *LawForms Integrity Agreement.* You may receive a copy of this standard form and information about it from our office. Unless we hear from you to the contrary, we shall assume that you are familiar with the *LawForms Integrity Agreement* or have taken the time to review and understand it.

   You have the right to consult with an attorney and ask questions of anyone in this office regarding the meaning of this form.
6. **FINANCE CHARGE.** If I don't pay the entire New Balance within 25 days of the monthly billing date a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $134.00) which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.
7. I consent to be photographed before, during, and after the treatment. These photographs shall be the property of the above doctor and may be published in dental journals, office manuals and/or shown for educational reasons.

Please Sign _____ Date

Please Continue

DENTAL / MEDICAL HISTORY FORM

Date | Patient Name | Date of Birth

Age | Social Security # | Sex ◯ Male ◯ Female

Do you have a specific dental problem? Describe ◯ Yes ◯ No

Do you have dental examinations on a regular basis? Last Visit ◯ Yes ◯ No

Would you describe your present dental health as good? Explain ◯ Yes ◯ No

Do you think you have active decay or gum disease? ◯ Yes ◯ No

Do your gums ever bleed? Explain ◯ Yes ◯ No

Do you brush and floss on a routine basis? Explain ◯ Yes ◯ No

Do you feel nervous about having dental treatment? ◯ Yes ◯ No

Have you ever had a bad experience in a dental office? Explain ◯ Yes ◯ No

Do you want to keep your remaining teeth? ◯ Yes ◯ No

Do you like your smile? Why? ◯ Yes ◯ No

Do you ever brux or grind your teeth? Explain ◯ Yes ◯ No

Have you ever had orthodontic treatment (tooth straightening) ◯ Yes ◯ No

Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? Explain ◯ Yes ◯ No

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Are you currently under the care of a physician? If so, for what reasons? ◯ Yes ◯ No

Name and address of Physician(s)

Phone number

Have you had any serious illness, operation, or hospitalization within the last five years? Explain ◯ Yes ◯ No

Are you currently taking any medications including non-prescription? Please list ◯ Yes ◯ No

Are you allergic to any medications or substances? Please list ◯ Yes ◯ No

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

Damaged heart valves, artificial valves or murmur? ◯ Yes ◯ No

Heart trouble, heart attack, angina, high blood pressure, stroke, or any heart condition? ◯ Yes ◯ No

Has your PHYSICIAN (not dentist) recommended you take antibiotics before dental treatment? ◯ Yes ◯ No

Rheumatic heart disease? ◯ Yes ◯ No

Chest pain upon exertion, or shortness of breath after mild exercise? ◯ Yes ◯ No

Swelling of feet, ankles, or hands? ◯ Yes ◯ No

Please Continue

Have you taken Cortisone, Prednisone, or any other steroids in the past two years? ◯ Yes ◯ No

Fainting spells or seizures? ◯ Yes ◯ No

Hepatitis A, B, C, Jaundice, or any other liver disease? ◯ Yes ◯ No

Asthma, Emphysema, Bronchitis or any other breathing problems? ◯ Yes ◯ No

Allergies, Hay Fever, sinus trouble, or frequent coughing? ◯ Yes ◯ No

Swelling of feet, ankles, or hands? ◯ Yes ◯ No

Diabetes? ◯ Yes ◯ No

Blood diseases (Anemia, Sickle Cell Anemia, Hemophilia)? ◯ Yes ◯ No

Artificial joints or hips? ◯ Yes ◯ No

Stomach problems such as ulcers, acid reflux, or hyper acidity? ◯ Yes ◯ No

Arthritis/Gout (Rheumatism, Osteoarthritis)? ◯ Yes ◯ No

Thyroid or Parathyroid disease? ◯ Yes ◯ No

Tuberculosis or Valley Fever? ◯ Yes ◯ No

Kidney Trouble? ◯ Yes ◯ No

Glaucoma or any other eye disorders? ◯ Yes ◯ No

Cancer, tumor, or growth? ◯ Yes ◯ No

Chemotherapy, X-ray treatment, for tumors or growths? ◯ Yes ◯ No

Problems with mental health? ◯ Yes ◯ No

Abnormal bleeding or bruise easily? ◯ Yes ◯ No

History of drug or alcohol abuse? ◯ Yes ◯ No

Blood transfusions? ◯ Yes ◯ No

Venereal diseases, STD's, AIDS, or Herpes? ◯ Yes ◯ No

Frequent or recurring mouth sores (cold sores, fever blisters)? ◯ Yes ◯ No

Surgically implanted device (heart valve, pace maker, defibrillator)? ◯ Yes ◯ No

Are you allergic to local anesthetics, latex or rubber products, or any other products? ◯ Yes ◯ No

WOMEN

Are you pregnant? How far along are you? ◯ Yes ◯ No

Are you taking any birth control pills? ◯ Yes ◯ No

Antibiotics may alter the effectiveness of birth control pills.

This may require some additional form of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is complete. Consult your physician/ gynecologist for assistance regarding additional methods of birth control.

DO YOU HAVE ANY OTHER CONDITIONS OR DISEASE YOU THINK DR. KOHLER SHOULD KNOW ABOUT?
(PLEASE EXPLAIN TO DR. KOHLER IN PERSON)

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I understand that if any change occurs in my health, I will report it to the office as soon as possible. I will not hold Dr. Kohler, nor any member of his staff responsible for any errors or omissions that I may have made during the completion of this form.

Patient or Guardian signature _____ Date _____

Dr. Kohler signature _____

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