

# NEW PATIENT INFORMATION SHEET

Date

Birth Date  Age

Social Security Number

Title  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

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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 \_\_\_\_\_