JAMES M KELLY D.D.S.

2999 N. 44TH St. Phoenix AZ 85018 602-954-1901

www.jamesmkellydds.com

PATIENT INFORMATION

Name__________________ ________________________________ Male
Female

Last First MI

Title: Dr. Mr. Mrs. Ms. How do you wish to be addressed? ______________________

Address: ____

Mailing Address City State Zip

Home #: __________________Work #: __________________Cell #:________________

Email Address: ____

Date of Birth: ________________ Social Security Number: ______________________

Who may we thank for referring you to our practice? ______________________________

DENTAL INSURANCE

Employee/Subscriber: ____

Date of Birth: ______________________ Subscriber ID#: _________________________

Employer: ____________________________ Group #: ___________________________

Insurance Company: ___________________________Phone #_____________________

______I authorize release of any information concerning my/my child's healthcare recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.

______ I authorize payment of insurance benefits directly to James M. Kelly D.D.S.

Patient/Guardian Signature: _____________________________Date: _______________

❺ *Medical History.*

Patient name ______________________ Birth date __________ Today's date __________

Date of last dental visit ______________________ Date of last xrays ______________________

Type of cleaning done: ☐ deep ☐ regular   Is there any pending treatment that was proposed by your last dentist? ☐ Yes ☐ No

Reason for leaving previous dentist? ______________________

Are you aware of any jaw pains or clenching/grinding? ☐ Yes ☐ No   Your height __________ Your weight __________

Any dental complaints/concerns you would like to be addressed today? ______________________

____

Are you happy about your smile? ☐ Yes ☐ No   If no, what would you like to change? ______________________

____

Are you under the care of a doctor? ☐ Yes ☐ No   If yes, what condition(s) are you being treated for? ______________________

____

Doctor's name ______________________ Phone (______) __________ Fax (______) __________

Date of last physical ______________________ Previous hospitalizations ______________________

____

Complications from any medical problems or hospitalizations ______________________

Have you ever had any of the following? *check all that apply*

- ☐ Allergies
- ☐ Arthritis or Rheumatism
- ☐ Artificial Heart Valves, Screws, etc.
- ☐ Infective Endocarditis
- ☐ Cardiac Transplant
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemical Dependency/ Recreational Drug Abuse
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone-Steroid Treatment
- ☐ Diabetes
- ☐ Epilepsy, Convulsions or Seizures
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hemophilia
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Hernia Repair __________
- ☐ Infectious Disease
- ☐ Kidney or bladder Disease
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recent Weight Loss __________
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems/Hayfever
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Swollen Ankles
- ☐ Thyroid Trouble
- ☐ Ulcer
- ☐ Sexually Transmitted Disease
- ☐ Fainting
- ☐ Sleep Apnea
- ☐ Tobacco Use (smoking or dip)
- ☐ History of HPV (Human Papillomavirus)
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Family History of Diabetes, Heart Disease, or Stroke

Has your doctor ever told you that you need to take antibiotic premedication prior to any dental appointment or procedure? (This is usually due to having had joint replacement, heart surgery, chemotherapy, etc.) ☐ Yes ☐ No If yes, explain. ______________________

____

Please list all prescription and over-the-counter medications you are currently taking and the reasons you take them. *(Attach list if needed)*

____

Allergies.

Do you have any drug allergies or have you ever had an adverse reaction to any medication, anesthetic, materials, or latex? ☐ Yes ☐ No If yes, what do you react to? ______________________

For women.

Are you pregnant, or do you suspect that you are pregnant? ☐ Yes ☐ No Due date __________

Are you nursing? ☐ Yes ☐ No   Are you taking birth control pills? ☐ Yes ☐ No

Medical History. *(cont.)* Patient name ______________________ Birth date __________ Today's date __________

Do you have any disease or condition not listed on the previous page, or anything about your health problem that we have not covered?

☐ Yes ☐ No If yes, please explain. ______________________________

Is there anything else we should know about your medical history? ______________________________

____

❻ *Emergency Contact Information.*

Please list the names and telephone numbers of two relatives (or friends) not living with you that we may contact in the case of an emergency.

Name ______________________ Relationship ______________ Phone (_____)______________

Address ______________________________

Name ______________________ Relationship ______________ Phone (_____)______________

Address ______________________________

❼ *Release.*

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I AM RESPONSIBLE TO INFORM THIS OFFICE OF ANY CHANGE IN HEALTH HISTORY.

X ______________________________

Signature *Date*

❽ *Health Information Authorization.*

I AUTHORIZE THE DENTAL OFFICE TO SHARE MY PROTECTED HEALTH INFORMATION WITH THE FOLLOWING PERSONS:

Name ______________________ Relationship ______________ Phone (_____)______________

Name ______________________ Relationship ______________ Phone (_____)______________

Name ______________________ Relationship ______________ Phone (_____)______________

❾ *HIPAA Release (Privacy Practices Documentation).*

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

____

Patient Name (please print) *Patient Birth Date*

X ______________________________

Signature *Date*

To Be Completed by Front Office

Written acknowledgement could not be documented due to the following reason(s):

☐ patient refusal to sign
☐ personal representative not available to sign
☐ language, communication, or effects of disability impeded acknowledgement
☐ emergency care impeded acknowledgement
☐ other, please specify______________________________

Dr James M. Kelly DDS

2999 N 44th St Suite 640

Phoenix, AZ 85018

HIPPA

______I acknowledge to have read and understand the Privacy Practices of James M. Kelly DDS. I also acknowledge to have offered a copy of these practices and may request additional copies in the future.

Cancellation Notice

______Please understand that Dr James M. Kelly DDS reserves the right to charge $75.00 for EACH HOUR YOUR appointment time was scheduled for If not cancelled or rescheduled within 48 business hours. You must speak with our office during business hours to make these changes or you will be billed accordingly.

My Financial Responsibility

______When scheduling Treatment with Dr James DDS HALF of patient portion will be due at the time of scheduling the treatment, and the other half day of treatment.

Insurance

______As a courtesy we will bill your insurance. It is your responsibility to know your eligibility and coverage.

Unpaid Balances/ Overdue Account

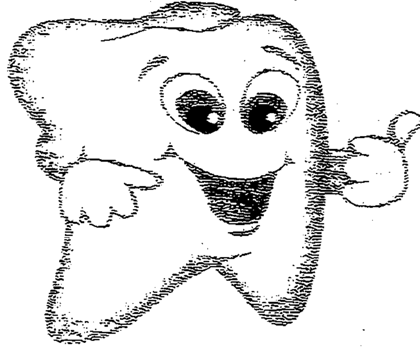
______All account(s) that reach 60 days late will be subject to a one-time $25 late fee. In addition, Dr. James M. Kelly reserves the right to charge interest on unpaid balances over 60 days a 1.5% interest fee on the incurred balance up to 18% per year. At 90 days we will be Filing a complaint with small claims Maricopa County Justice Court, and you will be Summoned.

I further agree to pay all finance charges, collection cost, attorneys fees and any other cost that may be incurred to collection of any amount outstanding.

I understand and agree to the terms of HIPAA, Cancellation, Insurance, and My Financial Responsibility

______________________ ______________________ ______________

Patient Name Patients Signature Date



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CONSENT TO DENTAL PHOTOGRAPHY

I, ______________________________ (Patient), authorize

Dr. James M Kelly DDS and Staff, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Check here if you do not want your full-face shot used for any of the above purposes ________

Signature (Patient) ______________________________

Date: ____________________