



# KANELLIS FAMILY DENTISTRY

*Michael Kanellis DMD*

## New Patient Information Form

Name: \_\_\_\_\_  Male  Female

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Referred by: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Parent/Guardian (if minor): \_\_\_\_\_

Employer: \_\_\_\_\_ SSN: \_\_\_\_\_

### Dental Insurance (Primary)

Insured's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Claim Mailing Address: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's SSN/ID #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

### Dental Insurance (Secondary)

Insured's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Claim Mailing Address: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's SSN/ID #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

#### Insurance Assignment:

I hereby authorize the above insurance companies to pay the benefits relative to the services performed on my claim to Kanellis Family Dentistry. I understand that I am financially responsible for all charges not covered by insurance.

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_

#### Consent:

1. I authorize the staff to take radiographs or utilize any other diagnostic aids to make a thorough diagnosis.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for such treatment. I understand that dental treatment and the use of anesthetic agents embodies a certain risk, including but not limited to nerve damage, bleeding, swelling and infection. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that 1 ½ % finance charge (18% APR) may be added to my account.
4. Lastly, I understand that where appropriate, credit bureau reports may be obtained.

**Patient X** \_\_\_\_\_ **Date:** \_\_\_\_\_

Guardian (if minor) X \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Please turn page over and complete the back side of the page. Thank you!**

## MEDICAL INFORMATION

1. Are you in good health? ..... Yes No
2. Have you been a patient in the hospital during the last two years?..... Yes No
3. Have you been under the care of a medical doctor during the past year?..... Yes No  
Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_
4. Have you taken any medication or drugs during the past two years?..... Yes No
5. Are you currently taking any medication or drugs?..... Yes No  
If yes, please list \_\_\_\_\_
6. Are you currently or have you in the past taken bisphosphonate drugs? (Actonel, Boniva, Fosamax etc.) Yes No
7. Are you allergic or sensitive to any medications or anesthetics?..... Yes No  
If yes, please list \_\_\_\_\_
8. Do you have any allergies or sensitivities to penicillin, local anesthetics, codeine or aspirin?..... Yes No
9. Do you have any allergies or sensitivities to metals, plastics or latex products?..... Yes No
10. Has a doctor ever told you that you need antibiotics prior to dental treatment?..... Yes No
11. Do you smoke or use tobacco products?..... Yes No
12. Do you use recreational drugs of any sort?..... Yes No

Please indicate which of the following you have at present, or have had. Circle Yes or No to each item.

Heart Failure	Yes No	Cortisone Medication	Yes No	Drug Addiction	Yes No
Heart Disease or Attack	Yes No	Kidney Trouble	Yes No	Hepatitis A (Infectious)	Yes No
Angina Pectoris	Yes No	Ulcers	Yes No	Hepatitis B (Serum)	Yes No
Congenital Heart Disease	Yes No	Diabetes	Yes No	Venereal Disease	Yes No
Heart Murmur	Yes No	Thyroid Problems	Yes No	A.I.D.S.	Yes No
High Blood Pressure	Yes No	Glaucoma	Yes No	H.I.V. Positive	Yes No
Stroke	Yes No	Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No
Arteriosclerosis	Yes No	Emphysema	Yes No	Excessive Bleeding	Yes No
Mitral Valve Prolapse	Yes No	Chronic Cough	Yes No	Blood Transfusion	Yes No
Artificial Heart Valve	Yes No	Sinus Trouble	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Asthma	Yes No	Anemia	Yes No
Heart Surgery	Yes No	Hay Fever	Yes No	Sickle Cell Disease	Yes No
Rheumatic Fever	Yes No	Allergies or Hives	Yes No	Bruise Easily	Yes No
Arthritis	Yes No	Cancer	Yes No	Liver Disease	Yes No
Rheumatism	Yes No	Radiation Therapy	Yes No	Yellow Jaundice	Yes No
Artificial Joints (hip, knee)	Yes No	Chemotherapy	Yes No	Epilepsy or Seizures	Yes No
Orthopedic Surgery	Yes No	Tumors	Yes No	Fainting or Dizzy Spells	Yes No
(Pins, Plates, Screws)		Unexplained Weight Loss	Yes No	Chronic Cough	Yes No
Night Sweats	Yes No	Blood from Coughing	Yes No	(over 3 weeks)	

13. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?.....Yes No
14. Have you ever come in close contact or lived in a concentrated housing environment with a Tuberculosis patient? Yes No
15. Do you have any diseases, conditions or problems not listed? .....Yes No  
If YES, please list \_\_\_\_\_

<b>FOR WOMEN ONLY:</b>	Are you pregnant? Yes No	Due Date: _____	No
	Are you nursing? Yes No	Are you taking birth control pills?	Yes No

Do you have a specific dental problem? \_\_\_\_\_  
 How long since your last dental visit? \_\_\_\_\_ Name of previous dentist: \_\_\_\_\_

**Specific Dental Concerns:**

Bleeding gums	Yes No	Unpleasant breath or bad taste	Yes No
Loose Teeth	Yes No	Sensitive to Hot, Cold, Sweets, Pressure	Yes No
Sensitive to Biting	Yes No	Clenching or Grinding of Teeth	Yes No
Popping/Clicking of Jaw	Yes No	Food Catching Between Teeth	Yes No
Pain on Opening/Closing	Yes No	Misaligned or Misshapen Teeth	Yes No
Headache or Muscle Pain	Yes No	Discolored Teeth	Yes No

Have you ever had orthodontic treatment?.....Yes No      Have you ever been told you have a gum problem?.....Yes No  
 Have there been any problems or complications related with previous dental treatment?.....Yes No  
 Does dental treatment make you nervous?.....Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

**Patient Signature X** \_\_\_\_\_ **Date:** \_\_\_\_\_



# KANELLIS FAMILY DENTISTRY

*Michael E. Kanellis, DMD*

## HIPAA NOTICE OF PRIVACY PRACTICES

Our commitment here at Kanellis Family Dentistry is to serve our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other Health Care Providers. The following are examples of instances where information may be shared:

- During treatment we may find it necessary to refer you to a Specialist, and the information we may provide to them would assist your treatment.
- To obtain payment for services we provide to you.

We may use or disclose your information to provide you with appointment reminders such as voicemail messages, post cards or letters.

You have the right to look at or get copies of your health information, with limited exception. We will not charge you any additional fee for such a request.

We are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided for by law, may revoke this written authorization at any time.

You may request a more detailed version of this notice at any time. If you have any questions or comments, feel free to contact us at (775)359-5072.

**I have read and understood the Notice of Privacy Practices.**

Print Name \_\_\_\_\_

Signature X \_\_\_\_\_ Date \_\_\_\_\_

**Patient or Legal Guardian**



KANELLIS FAMILY DENTISTRY  
*Michael E. Kanellis DMD*

## Appointment Cancellation Policy Agreement

Kanellis Family Dentistry is committed to providing all of our patients with exceptional care. We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (775) 359-5072 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a *Tuesday* appointment, please call our office by 2:00 p.m. on *Friday*. If prior notification is not given, you will be charged \$50 for the missed appointment.

Thank you for your understanding.

Please sign below to consent to these terms:

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Patient Signature (Patient's Parent/Guardian if under 18)

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Date