Kelly A. McKnight DMD

HEALTH HISTORY

Patient Name: Birth Date:

Personal Information

Address or Phone Number change	☐	If yes
Primary Doctor and Phone Number	☐	If yes
Cardiologist and Phone Number	☐	If yes
Orthopedic Surgeon and Phone Number	☐	If yes
Secondary Dentist and Phone Number if seasonal	☐	If yes

Are you taking any of the following medications?

Have you had any new surgeries or have been hospitalized since last appointment?	◯ Yes ◯ No	If yes
Have you OR are you currently taking Coumadin, Warfarin, Plavix, Pradaxa, Effient, Brilinta?	◯ Yes ◯ No	If yes
Have you OR are you currently taking any other blood thinners?	◯ Yes ◯ No	If yes
Have you OR are you currently taking Fosamax, Boniva, Actone, Zometa, Reclast?	◯ Yes ◯ No	If yes
Have you OR are you currently taking any other bisphosponate medications?	◯ Yes ◯ No	If yes

Women: Are you.....

☐ Pregnant/Trying to get preganant ☐ Nursing? ☐ Taking oral contraceptives?

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING AND INCLUDE WHAT THEY ARE FOR.

Are you allergic to any of the following?

☐ Local Anesthetics	☐ Penicillin	☐ Clindamycin	☐ Cephalexin
☐ Azithromycin	☐ Latex	☐ Sedatives	☐ Aspirin
☐ Codeine	☐ Sulfa Drugs		

Please list allergies not mentioned above: ◯ Yes ◯ No If yes

Please provide dates and specify if needed.

Have you ever had to premedicate prior to dental appointments?	◯ Yes ◯ No	If yes
Artificial Heart Valve	◯ Yes ◯ No	If yes
Congenital Heart Defects	◯ Yes ◯ No	If yes
Infectious Endocarditis	◯ Yes ◯ No	If yes
Congestive Heart Failure	◯ Yes ◯ No	If yes
Shunt/Stint/Pacemaker	◯ Yes ◯ No	If yes
Angina	◯ Yes ◯ No	If yes
AFIB	◯ Yes ◯ No	If yes
Any Other Heart Condtions	◯ Yes ◯ No	If yes
Stroke	◯ Yes ◯ No	If yes
Clotting Disorders	◯ Yes ◯ No	If yes
Artificial Joints	◯ Yes ◯ No	If yes
Respiratory Problems	◯ Yes ◯ No	If yes
Immune System Problems	◯ Yes ◯ No	If yes
Kidney Problems	◯ Yes ◯ No	If yes
Mental Health	◯ Yes ◯ No	If yes
Any Medical Condition Not Listed	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

High Blood Pressure	◯ Yes ◯ No	Diabetes Type I	◯ Yes ◯ No	Sexually Transmitted Disease	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No
Low Blood Pressure	◯ Yes ◯ No	Diabetes Type II	◯ Yes ◯ No	AIDS	◯ Yes ◯ No	Hepatitis B	◯ Yes ◯ No
Epilepsy	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Alzheimers	◯ Yes ◯ No	Hepatitis C	◯ Yes ◯ No
Seizures	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Dementia	◯ Yes ◯ No	Hepatitis D	◯ Yes ◯ No
Thyroid Problem	◯ Yes ◯ No						

Please specify type, date and area's treated.

Cancer	◯ Yes ◯ No	If yes
Undergoing or have had Chemotherapy	◯ Yes ◯ No	If yes
Do you have a port? (used for Chemotherapy)	◯ Yes ◯ No	If yes
Radiation to Head/Neck	◯ Yes ◯ No	If yes

Please List Surgeries Not Mentioned Above Including Dates

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

PATIENT INFORMATION

Name: _____ DOB: _____

Name of Guardian/Parent (if a child): _____

Phone # _____ Cell # _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____ Sex: M / F

Are you a seasonal resident? Yes No

If yes, Address: _____

City: _____ State: _____ Zip: _____

Person responsible for billing: _____

Emergency Contact: _____ Phone #: _____

Nearest relative: _____ Phone #: _____

Dental Insurance: Yes No Insurance Company: _____

Communication Preferences:
At this time we are offering communication through telephone calls. As we expand into other forms of communications, which would you prefer?

- ☐ Phone calls (if marked, please circle which phone line) HOME CELL
- ☐ Text messages (cell phone only)
- ☐ Email

Payment is expected at the time of service unless prior arrangements have been made with our front business office. As a courtesy to you, we will file most insurances. However, if after 60 days your insurance has not paid you will be expected to pay your balance in full. **If account is placed with collection agency, all fees incurred for the purpose of collecting the outstanding balance will be added to the account.**

_____

Patient/Parent Signature Date

KELLY
MCKNIGHT,
D.M.D.

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as a documented below:

Date:_____ Initials:_____ Reason:_____

Appointment Cancellation Agreement

Kelly McKnight Dentistry appreciates the confidence you have shown in choosing us to provide for your dental care needs. It is important for all patients to keep their dental appointments, and understand that missed appointments result in lost time that could have been used to provide care to another patient.

Rescheduling Appointments

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we require all patients to call at least 24 hours in advanced to cancel or reschedule any appointment.

Missed Appointments

If you miss or cancel appointments with less than 24 hours notice, a missed appointment note will be recorded in your account along with a $25.00 missed appointment fee.

I understand the dental appointment agreement and agree to follow the terms of the policy

Patient Signature Date

Patient Name (Please Print)

KELLY
MCKNIGHT,
D.M.D.

As a courtesy to our patients, we submit your treatment to your insurance company. We verify your insurance and provide you with an estimate of what your insurance company is expected to cover. We will collect the difference at the time of service. Reasonable efforts will be made to get your claims processed, however, after these efforts have been exhausted you will be required to pay your account balance in full. We ask that you be mindful that this is a courtesy provided to you as our patient. Ultimately you are responsible for your account balance.

Policy Holder: _____

Policy Holders Date of Birth: _____

Insurance Company: _____

ID # or SS #: _____ Group #:_____

Employer or Individual Plan: _____

Telephone # (Located on back of card): _____

_____ _____

Patient's Signature Date