KIRSCH FAMILY DENTISTRY

18 E. WASHINGTON ST.
GREENCASTLE, IN 46135
P: (765) 653-8615
F: (765) 653-5227

PATIENT INFORMATION

(Please Print in Blue or Black Ink)

Date_____

First Name _____Middle Initial _____Last Name_____

Preferred Name_____ Email Address _____

Address _____ City _____ State _____ Zip _____

Date of Birth_____ Age_____ Social Security #_____ Sex: □ Male □ Female

Home Phone (_____) _____ Work Phone (_____) _____ Cell (_____) _____

Best Contact Number: □ Home □ Work □ Cell May we call you at work? □ Yes □ No

- **Our office will contact you via Email & Text for appointment reminders. Please verbally tell us if you need to opt out.**
- **We electronically send our prescriptions, please list your preferred Pharmacy _____**

Marital Status: □ Married □ Divorced □ Separated □ Widow □ Single Spouse Name_____

Patient Employed: □ Full Time □ Part Time □ Retired □ No

Employer Name/Address_____ Phone #_____

Parent or Guardian Information (If minor)

Name: _____ Home Phone (___) _____ Cell (___) _____

Address_____City_____ State_____ Zip_____

Employer Name/Address_____ Phone #_____

Name of person responsible for this account _____ Relationship to patient_____

IN CASE OF EMERGENCY NOTIFY: Name:_____ Phone # (_____)_____

INSURANCE INFORMATION

Please Present Insurance ID Cards

PRIMARY DENTAL INSURANCE

Insurance Company _____

Employee Name _____

Employee Birthdate _____

Patient Relationship to Employee:

□ Self □ Spouse □Child □Other

Employee SSN _____

Employer _____

SECONDARY DENTAL INSURANCE

Insurance Company _____

Employee Name _____

Employee Birthdate _____

Patient Relationship to Employee:

□ Self □ Spouse □Child □Other

Employee SSN_____

Employer _____

AGREEMENT OF FINANCIAL RESPONSIBILITY, AUTHORIZATION, INSURANCE AND TREATMENT CONSENT

By my signature below I authorize the following: use of this form on all my insurance submissions, release of information to all my insurance carriers, my dentist to act as my agent in helping me obtain payment from my insurance carriers, payment directly to my dentist, and a copy of this authorization to be used in place of the original.

By my signature below, I consent to dental treatment.

By my signature below, I agree that I am responsible for my payment of any or all of the following: all fees not paid by my insurance including, but not limited to deductibles, co-pays, and disallowed services; any interest or fees assessed to my account for past due balances; all costs including, but not limited to, reasonable attorney fees, collection fees, and court costs.

Signature _____ Date _____

Printed Name _____ Relationship _____

(If patient is a minor)

PATIENT CONSENT TO SHARE PROTECTED HEALTH INFORMATION

Patient Name _____ Date _____

I hereby consent to **Elizabeth A. Kirsch, D.D.S. and/or staff of Kirsch Family Dentistry, LLC leaving a voicemail message at the number(s) indicated below and/or discussing with the individual(s) the information related to my protected health information (PHI). These communications may include, but are not limited to, appointment reminders, medications, pre-registering, billing and insurance items, and any information pertaining to clinical health services.**

With my consent, Elizabeth A. Kirsch, D.D.S. and/or staff of Kirsch Family Dentistry, LLC may disclose my PHI with the following individuals:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

I understand the information listed about may be communicated via: fax, photocopy, verbal communication, telephone, voice mail/and or direct mail.

If certain information is NOT to be included, please list: _____

YOUR RIGHTS WITH RESPECT TO THIS CONSENT:
I understand that I have the right to revoke this consent at any time by completing a new form.

_____

Signature of Patient or Legal Representative **Date**

(If signed by Legal Representative, state relationship and authority to do so)

Patient is ☐ **Minor** ☐ **Disabled** ☐ **Other – List** _____

Legal Authority: ☐ **Custodial Parent** ☐ **Legal Guardian**

☐ **Authorized Legal Representative**

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HEALTH HISTORY

(Please Print in Blue or Black Ink)

- Do you usually take an antibiotic prior to receiving dental treatment**?** □**Yes** □**No**

Do you have/ or have had any of the following? *Please Circle Y for yes and N for no.*

1.	**Y**	**N**	Heart Attack	20.	**Y**	**N**	Diabetes
2.	**Y**	**N**	Stroke	21.	**Y**	**N**	Problems with immune system
3.	**Y**	**N**	Artificial Heart Value	22.	**Y**	**N**	Infectious Mononucleosis
4.	**Y**	**N**	Mitral Valve Prolapse	23.	**Y**	**N**	Herpes
5.	**Y**	**N**	Cardiac Pacemaker	24.	**Y**	**N**	Arthritis
6.	**Y**	**N**	Defibrillator	25.	**Y**	**N**	Kidney Disease/ Dialysis
7.	**Y**	**N**	Irregular heartbeat	26.	**Y**	**N**	Thyroid Disease: hypo/hyper
8.	**Y**	**N**	High/Low Blood Pressure	27.	**Y**	**N**	Anxiety/Depression
9.	**Y**	**N**	Heart Surgery	28.	**Y**	**N**	Cancer, Tumor or Malignancy
10.	**Y**	**N**	Blood Thinner	29.	**Y**	**N**	Chemotherapy/ Radiation
11.	**Y**	**N**	Abnormal Bleeding Tendency	30.	**Y**	**N**	History of Drug Addiction
12.	**Y**	**N**	Anemia	31.	**Y**	**N**	HIV/ AIDS
13.	**Y**	**N**	Tuberculosis or Lung Disease	32.	**Y**	**N**	Immune Suppressed Disorder
14.	**Y**	**N**	Asthma/ Hay fever	33.	**Y**	**N**	Hearing Loss
15.	**Y**	**N**	COPD/emphysema/ difficulty breathing	34.	**Y**	**N**	Fainting Spells
16.	**Y**	**N**	Sinus Trouble	35.	**Y**	**N**	Glaucoma
17.	**Y**	**N**	Epilepsy/ Seizures	36.	**Y**	**N**	Emotional/Nervous Disorder
18.	**Y**	**N**	Liver Disease/Jaundice/ Hepatitis	37.	**Y**	**N**	Osteoporosis/bisphosphonates
19.	**Y**	**N**	Stomach Ulcers/ G.E.R.D/ Acid Reflux	38.	**Y**	**N**	Artificial Joint
							□ Knee □ Hip □ Shoulder □Other_____

NOTES:

- Do you smoke or use tobacco products? □ Yes □ No How many years? _____
- Have you had any illness, operation or been hospitalized in the past 5 years? □ Yes □ No
  If yes, please list procedures and dates:
  _____

Please list ALL medications (prescribed or OTC) you are currently taking: *or please provide us with a list*

□ NO MEDICATIONS TAKEN CURRENTLY.

Medication_____ Reason_____
Medication_____ Reason_____
Medication_____ Reason_____
Medication_____ Reason_____
Medication_____ Reason_____
Medication_____ Reason_____
Medication_____ Reason_____
Medication_____ Reason_____
Medication_____ Reason_____

ALLERGIES

Are you allergic to or had a reaction to:

Y	N	Penicillin	Y	N	Aspirin
Y	N	Sulfa Drugs/Sulfites/Sulfides	Y	N	Ibuprofen
Y	N	Other Antibiotics	Y	N	Codeine
Y	N	Local Anesthetics	Y	N	Other narcotics/pain medications
Y	N	Latex	Y	N	Other_____

Please describe reaction:

Have you ever had a reaction to Dental Treatment/s? **Y N**

If yes, Explain: _____

Have you ever had a complication or illness following dental treatment? **Y N**

If yes, Explain: _____

Is there anything in your medical/dental history that you feel our office should be aware of? **Y N**

If yes, Explain: _____

WOMEN: Are you pregnant? **Y N** If yes, Due Date: _____

Are you currently nursing? **Y N**

Are you taking birth control medications? **Y N**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above are answered to my satisfaction. I will not hold my dentist, or any other member of the staff, responsible for any errors or omissions I have made in the completion of this form.

Signature _____ Date _____

Printed Name_____ Relationship _____

(if patient is a minor)