Date_____ Acct #_____

PATIENT INFORMATION

Name_____
First MI Last "Go-By Name"

Home Address_____
City State Zip

Home #_____ Work #_____ Cell #_____

Patients Employer_____

Please circle for patient: male female // single married divorced widowed separated

Birth Date:_____ Social Security #:_____
month / date / year

Is patient a full time student? yes no Name of school:_____

E-Mail Address:_____

Is it ok to send appointment reminders via e-mail? yes no

Is it ok to send appointment reminders via text message? yes no

Person to contact for emergency:_____
Name Phone # Relationship

Pharmacy_____
Name Address Phone #

If you are a new patient, how did you hear about our office?
___ Friend / Family _____
___ Phonebook
___ Internet
___ Val-Pak
___ Kendrick Dental Care Team Member_____
___ Other_____

****

DENTAL INSURANCE INFORMATION

*Does patient have dental insurance coverage? yes/no -- If yes, please complete additional information.
Please allow us to make a copy of your current dental insurance card

Policy Holders Name (employee):_____

Employer:_____ Address:_____

Insurance Company:_____ Address:_____

SS#:_____ Birth Date: _____

Address:_____
City State Zip

Home Phone #:_____ Work Phone #:_____ Cell #_____

Relationship to patient (please circle one): self spouse child other_____

*Does patient have a secondary dental insurance? yes/no -- If yes, please complete additional information.
Please allow us to make a copy of your current dental insurance card

Policy Holders Name(employee):_____

Employer:_____ Address:_____

Insurance Co.:_____ Address:_____

SS#:_____ Birthday:_____

Address:_____
City State Zip

Home Phone #:_____ Work Phone #:_____ Cell #_____

Relationship to patient (please circle one): self spouse child other _____

****

CONSENT FOR TREATMENT

I hereby authorize Dr. Kerry L. Kendrick or designated staff to take x-rays, study models, photographs, and any other diagnostic aid deemed appropriate by Dr. Kerry Kendrick to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize Dr. Kerry Kendrick to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a late charge may be added to my account.

Patient_____ Date_____

Parent or Guardian/Responsible Party_____

Relationship to Patient_____

Witness_____

DENTAL HISTORY Patient Name _____

Welcome! *So that we may provide you with the best possible care, please complete both sides of this medical and dental history form. All information is completely confidential. Thank you.*

What is the reason for your visit today?_____

What was done at your last dental visit?_____

Previous Dentist's Name _____

_____

Address State Zip Phone #

Date of last dental visit _____ Last Dental Cleaning _____
Last Panoramic Xray _____ Last Bitewing xrays_____

How often do you have dental exams/cleanings? every 3 months - every 6 months - yearly - when there is a problem
How often do you brush your teeth? _____ How often do you floss? _____
What other dental aids do you use? Oral-B - Sonicare - Waterpik - Interplak
other_____
Do you have any dental problems now? yes no
If yes, please describe: _____
Are any of your teeth sensitive to:
Hot or cold? ---------- yes no
Sweets? ---------- yes no
Biting or Chewing? ---------- yes no
Have you noticed any mouth odors or bad taste?---------- yes no
Do you frequently get cold sores or fever blisters?---------- yes no
Do your gums bleed or hurt?---------- yes no
Have your parents experienced gum disease or tooth loss?------- yes no
Have you noticed any loose teeth or change in your bite?--------- yes no
Does food tend to become caught in between your teeth?-------- yes no

Do you:
clench or grind your teeth?---------- yes no
bite your lips or cheeks regularly?---------- yes no
hold foreign objects with your teeth like pencils, pipe, pins or nails?--------- yes no
mouth breath while awake or asleep?---------- yes no
have tired or sore jaws, especially in the morning?---------- yes no

Have you ever had:
orthodontic treatment? (braces)---------- yes no
If so, at what age _____
oral surgery? (wisdom teeth)---------- yes no
If so, at what age _____
periodontal treatment? (gum disease)---------- yes no
If so, how long ago? _____
your teeth ground or the bite adjusted?---------- yes no
a bite plate or mouth guard made?---------- yes no
a serious injury to the mouth or head?---------- yes no
If so, please describe:_____

Have you experienced:
clicking or popping of the jaw?---------- yes no
pain? (joint, ear, side of face)---------- yes no
difficulty in opening or closing the mouth?---------- yes no
difficulty in chewing on either side of the mouth?--------- yes no
headaches, neck aches or shoulder aches?---------- yes no

Are you satisfied with your teeth's appearance? --------yes no
Are you happy with your smile?---------- yes no
Would you like to keep all of your teeth all of your life?------yes no
Do you feel nervous about having dental treatment?-------- yes no
If so, what is your biggest concern?_____
Have you ever had an upsetting dental experience?-------- yes no
If yes, please describe:_____
Is there anything else about having dental treatment that you would like us to know?--------- yes no
If yes, please describe:_____
_____

KENDRICK DENTAL CARE

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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 _____ DATE _____

Kendrick Dental Care
Kerry L. Kendrick, DDS
203 Chase Drive, Hurricane, WV 25526
(304) 757-7792
(304) 757-7808
KendrickDentalCare@suddenlinkmail.com

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provide safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with the quality professional service and care. Addition information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters relate to your care and handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding with identifies a patient's condition or information which is not already a matter of public record. The normal cause of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI by must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concern or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Kendrick Dental Care
203 Chase Drive
Hurricane, WV 25526
304-757-7792

OFFICE FINANCIAL POLICY

Payment is due at the time services are rendered. For your convenience we accept cash, VISA, MasterCard, Discover, American Express, CareCredit, personal checks, money orders or registered checks.

Kendrick Dental Care is not a participating provider for *any* insurance company, we are considered out of network. As a courtesy, we will bill your insurance company, but you are responsible for any outstanding balance that your insurance company does not cover.

Insurance Benefits are determined by your employer and not your dentist. **Any deductible or estimated co-payment amount will be due at the time of treatment.** Insurance is not a guarantee of payment; they will not pay for all your costs. Your insurance policy is a contract between you and your insurance company. Your insurance and payment is still your responsibility. As a courtesy we will be glad to file your claim for you if you bring: 1) your dental insurance wallet card and 2) all required employer information. You will be expected to pay for services rendered if our office is unable to verify your insurance information before treatment. **If payment for services already rendered has not been paid in full within 40 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible from you.**

We reserve the right to charge, and collect, fees for Broken Appointments - appointments that are cancelled or broken without 48 hours advance notice. Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Outstanding Balances that have not received a payment in the last 60 day will be charged a 2.25% finance charge.

Returned Check Fee of $30.00 will be added to your account balance and is collectible.

Payment plans and financial arrangements can be entered into for comprehensive dental treatment treatment, prior to commencing treatment.

I have read and understand this financial policy.

_____	_____	_____
Print name	**Signature**	**Date**



KENDRICK DENTAL CARE

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203 Chase Drive
Hurricane, WV 25526
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SUPPLEMENTAL INFORMED CONSENT

Dental Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and will continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have take measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dental health care providers, staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes_____ No_____

_____ _____

Patient / Parent's Signature (must be at least 18 to sign) Date