Mark Kesler D.D.S., P.C.

Patient Health Record

Date_____
Name(last, first, middle initial)_____
Address(street,apt.#,city,state,zip code)_____
_____
Home Phone_____Work Phone_____
Date of Birth_____Your Social Security Number_____
Marital Status(circle one): single married
Spouse's Name_____
Your Employer_____Occupation_____
Name and address of Dental Insurance Co:_____
_____
_____
Insured person's name (ex: you, spouse/parent's name)_____
Insured person's social security number_____
Dental Insurance Group or Account Number_____
Referred by_____

Dental Health

When was your last dental exam/cleaning?_____
Have you had any serious problems with dental treatment? Please explain if so.
_____
_____
_____
Are you having any pain/problems at this time?_____
_____
Do your gums bleed when you brush or floss? Yes No
Have you lost any teeth? Yes No If yes, when?_____
Are you having any TMJ problems (clicking or pain in the jaw muscle)? Yes No
Would you like to change the shape or alignment of your teeth? Yes No
Would you like to have whiter teeth? Yes No
Why did you leave your last dentist?_____
_____

Financial Policies

Once you have provided our office with your current dental insurance information, we will be happy to file all necessary claims for you at no extra charge. However, the patient needs to realize that the insurance agreement is between the insurance company and the patient and not with the doctor. We request those patients with insurance to pay their respective co-payments at the time of treatment. If there is a balance after insurance responds the patient is required to pay that amount.

Patients not having dental insurance will be required to pay for services when treatment is rendered. For cases requiring multiple visits, ½ of the total fee will be due at the initial visit. Full payment must be made at completion of treatment unless other arrangements have been made.

A 24 hour notice is required to cancel or reschedule an appointment or there will be a $50 fee.

Please understand that if payment is not made when due, the account may be turned over for collections. You will be responsible for any and all costs associated with the collection procedure, including but not limited to billing costs, collection fees, lawyer's fees, and court costs.

NAME_____DATE_____

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Medical Record

Are you currently under the care of a physician? . . . . . yes no
If yes, name of physician?_____
For what reason?_____

Have you ever been treated for any of the following?
Hepatitis, jaundice, or liver disease . . . . . yes no
Tuberculosis or lung disease . . . . . yes no
Congenital heart lesions . . . . . yes no
Damaged/artificial heart valves . . . . . yes no
Heart murmur . . . . . yes no
HIV/AIDS . . . . . yes no
Rheumatic fever . . . . . yes no
Cardiovascular disease (heart attack, stroke, arteriosclerosis, coronary occlusion, pacemaker, high blood pressure) – please circle all that apply . . . . . yes no
Artificial joint replacement . . . . . yes no
Allergy/hay fever . . . . . yes no
Sinus trouble . . . . . yes no
Asthma . . . . . yes no
Diabetes . . . . . yes no
Epilepsy/seizures . . . . . yes no
Cancer . . . . . yes no
Psychiatric problems . . . . . yes no
Ulcers . . . . . yes no
Arthritis . . . . . yes no
Anemia . . . . . yes no
Glaucoma . . . . . yes no
Fainting spells . . . . . yes no
Kidney trouble . . . . . yes no

Are you allergic to penicillin, codeine, aspirin, local anesthetics? (circle) . yes no
Other medicines_____
Are you currently taking any medications? . . . . . yes no
If yes, what medication & why?_____
Women: are you pregnant? . . . . . yes no
If yes, expected due date_____
Are you subject to prolonged bleeding? . . . . . yes no
Do you have any condition/problem/disease that we should know about? . . yes no
If yes, please explain_____

Signature_____

Medical History update:_____
Medical History update:_____
Medical History update:_____
Medical History update:_____