Welcome

KIZER DENTISTRY

11161 Kingston Pike, Suite 1
Farragut, TN 37934

ABOUT YOU

Patient Name:_____ Today's Date:_____/_____/_____
Last First MI

What you prefer to be called:_____ Birthdate:____/____/____ Age:____

SS #:_____

Mailing Address:_____

_____
City State Zip

Home Phone #:(_____)_____ Work Phone #:(_____)_____ Ext:_____

Cell Phone #:(_____)_____ E-mail Address:_____

Referred By:_____

Employer:_____

Employer's Address:_____

_____
City State Zip

Occupation:_____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name:_____

ACCOUNT INFO

Person ultimately responsible for account

❑ Same as patient information above

Name:_____

Relation:_____

Billing Address *(if different than above)*:

_____

_____
City State Zip

SS #:_____

Work Phone #:(_____)_____

Payment Method: ❑ Cash ❑ Check ❑ Credit Card

Initials_____ *I hereby authorize assignment of my insurance services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).*

INSURANCE INFO

Subscriber Name: _____

Date of Birth:_____

ID Number: _____

Employer:_____

ALSO, PLEASE BRING YOUR INSURANCE CARD TO BE PHOTOCOPIED.

IN EVENT OF EMERGENCY

Whom should we contact?_____

Relation:_____

Home Phone #:(_____)_____

Work Phone #:(_____)_____

Cell Phone #:(_____)_____

Who is your medical doctor?_____

Medical Doctor's Phone #:(_____)_____

Please Continue on Back ➔

DENTAL INFORMATION

Reason for today's visit:_____

Are you in pain? ❑ Yes ❑ No How Long?_____

Are you happy with your smile? ❑ Yes ❑ No Explain:_____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't Know

Last Dental Exam:_____/_____/_____ Last Dental X-rays:_____/_____/_____

MEDICAL HISTORY

Please list all medications you are taking:_____

_____

Do you have or have you had any of the following diseases, medical conditions or procedures?
Please place a check mark beside all that apply:

❑ Heart Attack/Stroke	❑ Heart Surg./Pacemaker	❑ Heart Murmur	❑ Rheumatic Fever
❑ Mitral Valve Prolapse	❑ Artificial Valves	❑ Heart Disease	❑ Congenital Heart Defect
❑ Chest Pains	❑ Scarlet Fever	❑ Nervousness	❑ Thyroid Problems
❑ Kidney Problems	❑ Liver Problems	❑ Respiratory Problems	❑ Sinus Problems
❑ Stomach Problems/Ulcers	❑ Psychiatric Problems	❑ Venereal Disease	❑ Alcohol/Drug Abuse
❑ Tuberculosis TB	❑ Jaw Problems TMJ/TMD	❑ Cancer/Tumors	❑ Shingles
❑ Hepatitis	❑ HIV+/Aids/ARC	❑ Arthritis/Rheumatism	❑ Artificial Bones/Joints
❑ Emphysema	❑ Fainting/Seizures/Epilepsy	❑ Severe/Frequent Headaches	❑ Frequent Neck Pain
❑ Back Problems	❑ Cosmetic Surgery	❑ Xray or Cobalt Treatment	❑ Chemotherapy
❑ Asthma	❑ Difficulty Breathing	❑ Diabetes/Hypoglycemia	❑ Leukemia
❑ Anemia	❑ High/Low Blood Pressure	❑ Bleeding Problems	❑ Glaucoma

Please list any other surgeries or medical conditions you have or ever had:_____

_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Aspirin
❑ Dental Anesthetics ❑ Others:_____

Do you use tobacco? ❑ No ❑ Yes/How used?_____ How much?_____ How long?_____

For women: Are you pregnant? ❑ No ❑ Yes/How long?_____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date____/____/____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(Office Use)

Initials ____/____/____ Date
Comments

Initials ____/____/____ Date
Comments

Initials ____/____/____ Date
Comments