Patient Information DATE: ____________

Patient Name: ____
Last, First MI (Preferred Name)

SS#: ______________ DOB: ______________ DL#: ______________

Address: ____
Street Apartment #

____
City State Zip Code

We now confirm appointments by email AND text.

EMAIL: ______________________ Cell: ______________________

Home: ______________ Work: ______________ ext.: ________

Employer: ______________________ Occupation: ______________________

Name of person or office referring you to our practice? ______________________

EMERGENCY CONTACT: ______________________**; Relationship to you:** ______________
Name AND Contact #

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________ SS#: ______________ DOB: ______________

Address: same as above? Y N If No, please fill out the following:

____
Street Apartment #

____
City State Zip Code

Employer: ______________________ Occupation: ______________________

Insurance Information

IF YOU HAVE A DENTAL INSURANCE CARD- please let the front office make a copy and you can skip this next step. If no dental card is present, please fill out as best as you can. Thank you.

Name of Insured: ______________________ Relationship to Patient: ______________

Birthdate: ______________ SS#: ______________

Insurance Company/Carrier: ______________________ ID#: ______________________

Group #: ______________ Customer Service Phone #: ______________________

Claim Mailing Address: ____

Dental History

Do your gums bleed when you brush or floss? YES NO

Are your teeth sensitive to hot, cold, sweets, or pressure? YES NO

Does food or floss catch between your teeth? YES NO

Are you currently experiencing dental pain or discomfort? YES NO

Are you aware of any chipped or broken teeth? YES NO

How do you feel about your smile? ____

Health History

DATE: ____________________

Have you been hospitalized in the last 5 years? YES NO
IF YES, please give reason:
____

Cardiovascular Disease (heart trouble, heart attack, heart murmur, artificial heart valve, or mitral valve prolapse) YES NO

ARE YOU ON A BLOOD THINNER OR BABY ASPIRIN? YES NO

Condition			Condition		
Pacemaker	YES	NO	HIV Positive or AIDS related complex	YES	NO
High Blood Pressure	YES	NO	Low Blood Pressure	YES	NO
Diabetes	YES	NO	Kidney Trouble or Dialysis	YES	NO
Hepatitis, any form	YES	NO	LATEX sensitivity or allergy	YES	NO
Artificial Joints	YES	NO	Liver Disease including Jaundice	YES	NO
Anemia	YES	NO	Psychosis or Anxiety Disorder	YES	NO
Arthritis	YES	NO	Sleep Apnea or use of C-pap	YES	NO
Asthma	YES	NO	Stomach or Intestinal Problem	YES	NO
Blood Disease	YES	NO	Stroke	YES	NO
Cancer	YES	NO	Thyroid Disorder	YES	NO
Emphysema	YES	NO	Tuberculosis	YES	NO
Epilepsy or Seizures	YES	NO	Radiation Therapy (Head or Neck)	YES	NO
Glaucoma	YES	NO	Do you use tobacco products?	YES	NO

Women: Are you currently pregnant? YES NO
Any condition that could require pre-medication (such as knee/hip replacement) YES NO

Known allergies to these medications (please circle): Penicillin, Codeine, Sulfa, or "Mycins"? YES NO

Known allergies to any other drugs (please list): ______________________________

Any other disease, condition, or problem NOT listed above that we should know about?
____

Please list all medications you are currently taking, including prescriptions, over the counter medications and/or herbal remedies:
IF you have a personal prescription list, we will be happy to make a copy for you.
____
____
____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

PATIENT, PARENT OR GUARDIAN: ______________________________ **DATE:** ____________________

Reviewed by Doctor: ______________________________ **DATE:** ____________________

MEDICAL UPDATES

I have read my medical history dated ____________________ and confirm that it adequately states past & present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	BP	REVIEWED BY
				DR.________
				DR.________
				DR.________
				DR.________
				DR.________
				DR.________
				DR.________
				DR.________
				DR.________
				DR.________
				DR.________
				DR.________
				DR.________
				DR.________
				DR.________

KITT DENTAL

DR. PARRIS KITT
10752 FM 2813 FLINT, TX 75762
Phone: 903-561-4477 ~ Fax: 903-561-4475

Payment & Financial Policies

As a service to our patients, we will file insurance claims on your behalf for services rendered in our office. Please let us know if you have any questions.

The patient or patient's guarantor is responsible for all charges incurred in our office.

Patients with NO DENTAL INSURANCE- CASH PAY:

- Payment is due in full upon services rendered unless other payment arrangements have been made PRIOR to treatment.

Patients WITH DENTAL INSURANCE coverage:

- We can only **estimate** what your insurance will pay for services rendered.
- Your dental insurance is a contract between you (the patient or guarantor) and the insurance carrier- not Kitt Dental or Dr. Kitt.
- Any payments received by Kitt Dental from your insurance company will be credited to your account; however, after 60 days all outstanding balances are the responsibility of the patient or the patient's guarantor.
- If your insurance company sends you the check instead of sending it to us- you will owe us what we expected from insurance. You may sign over the check to our office or cash it and then pay us the balance owed. We are trusting you in this matter, any issues with this and we may require you to pay entire balance upfront and have insurance reimburse you.

Cancellation & Communication Policy

We want you to be here! In fact, we set aside a very special time just for YOU! If for any reason you know that you cannot make your appointment, please give us at least a 48 hour notice so we can make an attempt to fill that time.
To help remind you of any future appointments, we send out several friendly text reminders.
Be advised, if you STOP/OPT out of our text messages you are still responsible for your scheduled appointment.

Please realize IF you do not reply to the reminders received, we will call you to confirm your appointment.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Printed Patient Name: ____ **Date:** ________________

Patient or Parent/Guardian's Signature: ____

KITT DENTAL
DR. PARRIS KITT
10752 FM 2813 FLINT, TX 75762
Phone: 903-561-4477 ~ Fax: 903-561-4475

General Informed Consent for Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatment, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is especially important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of poor outcomes.

Please read and initial the items below and sign at the bottom of the form.

Treatment to be provided

I understand that during my course of treatment that the following care may be provided:
Examinations, Preventative Services, Diagnosis, LASER Therapy
I understand images may be taken and used at the discretion of Kitt Dental

(Initials______)

Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

(Initials______)

Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions, as necessary.

(Initials______)

COVID-19 Acknowledgement of Risk & Health

Although we are using quality infection control measures in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing during treatment or for you to wear a mask during treatment. This means that the risk of exposure to COVID-19 remains when receiving treatment. I acknowledge that I have read the above statement and I understand and accept that there is a risk of COVID-19 exposure with treatment.

(Initials______)

Social Media Consent/Release

I am aware photos of my teeth/mouth may be used in various publications. No full facial shots or names will be used without specific permission. I may revoke this release in writing at any time.

(Initials______)

Printed Patient Name: ____ **Date:** ________________

Patient or Parent/Guardian's Signature: ____