Kimberly S. CHRISTMAN, DDS
FAMILY AND COSMETIC DENTISTRY

Health History

Thank You For Selecting Us.

To help us meet all your healthcare needs, please print and fill out this form completely in ink. If you have any questions please contact us and we will be happy to help.

Patient Information (confidential)

Name_____Date_____
SS#/SIN_____ Birth Date_____ Home Phone_____
Address_____
City_____ State/Prov._____ Zip/P.C._____
Email_____ Cell Phone_____
Check Appropriate Box: □ Minor □ Single □ Married □ Separated □ Divorced □ Widowed
If Student, Name of School/College_____
City_____ State/Prov._____ Zip/P.C._____Full Time Part Time
Patient or Parent/Guardian's Employer_____ Work Phone_____
Business Address_____
City_____ State/Prov._____ Zip/P.C._____
Patient or Parent/Guardian's Name_____ Employer_____Work Phone_____
Whom May We Thank For Referring You?_____
Person to Contact in Case of Emergency_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____
Address_____ Home Phone_____
Email_____ Cell Phone_____
Drivers License #_____ Birth Date_____ Financial Institution_____
Employer _____Work Phone_____SS/SIN_____
Is this Person Currently a Patient in our Office? Y□ N□
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
□ Cash □ Personal Check □ Credit Card □ Visa □ Mastercard □ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured_____ Relationship to Patient_____
SS#/SIN_____ Birth Date_____ Date Employed_____
Name of Employer_____ Union or local #_____ Work Phone_____
Employer Address_____
City_____ State/Prov._____ Zip/P.C._____
Insurance Company _____ Group #_____ Policy/I.D.#_____
Ins. Co. Address_____
City_____ State/Prov._____ Zip/P.C._____
How Much is Your Deductible?_____ How Much Have You Used? _____ Max Annual Benefit_____

Do You Have Any Additional Insurance? Y☐ N☐ If Yes Complete the Following:

Name of Insured_____ Relationship to Patient_____
SS#/SIN_____ Birth Date_____ Date Employed_____
Name of Employer_____ Union or local #_____ Work Phone_____
Employer Address_____
City_____ State/Prov._____ Zip/P.C._____
Insurance Company _____ Group #_____ Policy/I.D.#_____
Ins. Co. Address_____
City_____ State/Prov._____ Zip/P.C._____
How Much is Your Deductible?_____ How Much Have You Used? _____ Max Annual Benefit_____

Patient Medical History

Physician_____ Office Phone _____ Date of Last Exam_____

1. Are you under medical treatment now? Y☐ N☐
2. Have you ever been hospitalized for a surgical operation or serious illness in the last five years? If yes, please explain Y☐ N☐
_____
_____

3. Are you taking any medication(s) including non-prescription medicine? Y☐ N☐
If yes, what medication(s) are you taking?
_____
_____
_____

4. Have you ever taken Fen-phen/Redux? Y☐ N☐
5. Do you use tobacco? Y☐ N☐
6. Do you use controlled substances? Y☐ N☐
7. Are you wearing contact lenses? Y☐ N☐
8. Have you had any of the following?

9. Are you allergic to or have you had any reactions to any of the following:

	Local
anesthetics (e.g. novocaine)	Y☐ N☐
Penicillin or any other Antibiotics	Y☐ N☐
Sulfa Drugs	Y☐ N☐
Barbiturates	Y☐ N☐
Sedatives	Y☐ N☐
Lodine	Y☐ N☐
Aspirin	Y☐ N☐
Any Metals (e.g. nickel, mercury etc.)	Y☐ N☐
Latex Rubber	Y☐ N☐
Other_____	Y☐ N☐

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than three weeks)? Y☐ N☐
11. Women Only:
Are you, or do you think you may be pregnant? Y☐ N☐
Are you nursing? Y☐ N☐
Are you taking oral contraceptives? Y☐ N☐

High blood pressure	Y☐ N☐	Heart Disease	Y☐ N☐	Chest Pains	Y☐ N☐
Heart Attack	Y☐ N☐	Cardiac Pacemaker	Y☐ N☐	Easily Winced	Y☐ N☐
Rheumatic Fever	Y☐ N☐	Heart Murmur	Y☐ N☐	Stroke	Y☐ N☐
Swollen Ankles	Y☐ N☐	Angina	Y☐ N☐	Hay Fever/Allergies	Y☐ N☐
Fainting/Seizures	Y☐ N☐	Frequently Tired	Y☐ N☐	Tuberculosis	Y☐ N☐
Asthma	Y☐ N☐	Anemia	Y☐ N☐	Radiation therapy	Y☐ N☐
Low Blood Pressure	Y☐ N☐	Emphysema	Y☐ N☐	Glaucoma	Y☐ N☐
Epilepsy/Convulsions	Y☐ N☐	Cancer	Y☐ N☐	Recent Weight Loss	Y☐ N☐
Leukemia	Y☐ N☐	Arthritis	Y☐ N☐	Liver Disease	Y☐ N☐
Diabetes	Y☐ N☐	Heart Trouble	Y☐ N☐	AIDS/HIV Infection	Y☐ N☐
Hepatitis/Jaundice	Y☐ N☐	Respiratory Problems	Y☐ N☐	Sexually Transmitted Disease	Y☐ N☐
Mitral Valve Prolapse	Y☐ N☐	Thyroid Problem	Y☐ N☐	Joint Replacement or Implant	Y☐ N☐
Stomach Troubles/Ulcers	Y☐ N☐	Kidney Disease	Y☐ N☐	Other_____	Y☐ N☐

Patient Dental History

Name/Location of Previous Dentist_____ Date of Last Exam_____

1. Do your gums bleed while brushing or flossing?	Y☐	N☐
2. Are your teeth sensitive to hot or cold liquids/foods?	Y☐	N☐
3. Are your teeth sensitive to sweet or sour liquids or foods?	Y☐	N☐
4. Do you feel pain in any of your teeth?	Y☐	N☐
5. Do you have any sores or lumps in or near your mouth?	Y☐	N☐
6. Have you had any head, neck or jaw injuries?	Y☐	N☐
7. Have you ever experienced any clicking in your jaw?	Y☐	N☐
8. Have you ever experienced any pain (joint, ear, side of face)?	Y☐	N☐
9. Have you ever experienced any difficulty in opening or closing your jaw?	Y☐	N☐
10. Have you ever experienced any difficulty in chewing?	Y☐	N☐
11. Do you have frequent headaches?	Y☐	N☐
12. Do you clench or grind your teeth?	Y☐	N☐
13. Do you bite your lips or cheeks frequently?	Y☐	N☐
14. Have you ever had difficult extractions in the past?	Y☐	N☐
15. Have you ever had any prolonged bleeding following an extraction?	Y☐	N☐
16. Have you had any orthodontic treatment?	Y☐	N☐
17. Do you wear dentures or partials? If yes, date of placement_____	Y☐	N☐
18. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Y☐	N☐
19. Do you like your smile?	Y☐	N☐

Authorization and Release

I certify that I have read and understand the above information to be the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I Authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I realize and request my insurance company to pay directly to the Dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

_____

Signature of Patient/Responsible Party Date

Doctor's Comments_____

_____

_____

Signature _____Date _____

Kimberly S. CHRISTMAN, DDS
FAMILY AND COSMETIC DENTISTRY

ASSIGNMENT OF BENEFITS AGREEMENT

As a courtesy to our patients, our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction, Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment. _____

- We require you to sign this form and or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office. _____

- We require you to pay the co-insurance amount, which is the amount not covered by your insurance company at the time we provide service to you. _____

- Insurance payments ordinarily are received within thirty to sixty days from the time of billing. If your insurance company has not made payment to our office within sixty days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time. _____

- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time. _____

- Our office will not enter into a dispute with your insurance company over any claim, Although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company. _____

I Have Read And Understand The Above Conditions. I Hereby Authorize My Insurance Company To Pay My Dental Benefits Directly To The Doctor.

_____
Signature of Patient/Responsible Party

_____
Date

Kimberly S. CHRISTMAN, DDS
FAMILY AND COSMETIC DENTISTRY

FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality of dental care utilizing only the best materials and education available. In our process of doing so, we have formulated a financial policy to continue to provide excellent service to you and minimize our administrative costs.

- **Payment is due at the time service is provided.** Our office accepts cash, personal checks, Mastercard, Visa. Outside financing is available upon request and approved credit.

- For those of you with dental insurance, as a courtesy, we will assist you in processing your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the **Assignment of Benefits Agreement**. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment. Your deductible and coinsurance if applicable is due when services are provided.

- All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer and the insurance company. Our office is not a party to that contract or any possible restrictions.

- Returned checks and balances older than sixty days will be subject to collection fees of $25.00, at a minimum, and finance charges at the rate of 1.5% per month (18% annually). Additionally, charges may be incurred for broken appointments; and appointments cancelled without forty-eight hour advance notice.

If you have any questions regarding our financial policy, please do not hesitate to ask. We are committed to providing you with the most positive experience in dental care.

_____
Signature of Patient/Responsible Party

_____
Date

Kimberly S. CHRISTMAN, DDS
FAMILY AND COSMETIC DENTISTRY

Notice of Privacy Practices Acknowledgement

Kimberly S. Christman, D.D. S., PA
17824 Statesville Road Suite 111
Cornelius, N.C. 28031
(704) 895-3775 PHONE (704) 895-3770

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason