Kenneth L. Andow
D D S • P C

# Emergency Patient Information

*A lifetime of healthy smiles for your entire family*

Name: _____ Date: _____

What name would you like to be called: _____ Date of Birth: _____

Home Phone: _____ Social Security No: _____ Marital Status: ◯S ◯M ◯D ◯W

Cell Phone: _____

E-mail: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____

Work Address: _____ City: _____ State: _____ Zip Code: _____

Work Phone: _____ Occupation: _____

Dental Insurance Company: _____ Group#: _____

Whom may we thank for referring you to our office? _____

Account information/responsible party for patient: _____

Reason for today's visit? _____

## Medical History

Mark "YES" or "NO" next to each item.

Have you been under the care of a medical doctor during the past two months? YES◯ NO◯

If yes, why? _____

Have you ever been hospitalized for any serious illness or operation? YES◯ NO◯

If yes, please list: _____

Are you currently taking any medications, drugs or pills on a regular basis? YES◯ NO◯

If yes, please list: _____

Are you allergic to or have you ever reacted adversely to any medications? YES◯ NO◯

If yes, please list: _____

Indicate which of the following you have had or have at present. Mark "YES" or "NO" next to each item.

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Heart Failure | YES◯ NO◯ | Anemia | YES◯ NO◯ | Sinus Trouble | YES◯ NO◯ | Arthritis/Gout | YES◯ NO◯ | Artificial Heart Valve | YES◯ NO◯ | Nervousness | YES◯ NO◯ |
| Artificial Joints | YES◯ NO◯ | Shortness of Breath | YES◯ NO◯ | Liver Disease | YES◯ NO◯ | Cancer | YES◯ NO◯ | Cortisone Medicine | YES◯ NO◯ | Heart Surgery | YES◯ NO◯ |
| Chronic Cough | YES◯ NO◯ | Diabetes | YES◯ NO◯ | High Blood Pressure | YES◯ NO◯ | Alzheimer's Disease | YES◯ NO◯ | Hepatitis B (serum) | YES◯ NO◯ | Stroke | YES◯ NO◯ |
| Blood Transfusion | YES◯ NO◯ | Hay Fever | YES◯ NO◯ | Cosmetic Surgery | YES◯ NO◯ | Arteriosclerosis | YES◯ NO◯ | Parathyroid Disease | YES◯ NO◯ | HIV Positive | YES◯ NO◯ |
| Angina Pectoris | YES◯ NO◯ | Sickle Cell Disease | YES◯ NO◯ | Radiation Therapy | YES◯ NO◯ | Lung Disease | YES◯ NO◯ | Chest Pain | YES◯ NO◯ | Psychiatric Treatment | YES◯ NO◯ |
| Kidney Trouble | YES◯ NO◯ | Heart Disease | YES◯ NO◯ | Yellow Jaundice | YES◯ NO◯ | Anti-Cancer Drugs | YES◯ NO◯ | Drug Addiction | YES◯ NO◯ | Valvular Dysfunction | YES◯ NO◯ |
| Tuberculosis (TB) | YES◯ NO◯ | Thyroid Problems | YES◯ NO◯ | Low Blood Pressure | YES◯ NO◯ | Hypoglycemia | YES◯ NO◯ | Hepatitis C | YES◯ NO◯ | Excessive Thirst | YES◯ NO◯ |
| Hemophilia | YES◯ NO◯ | Allergies or Hives | YES◯ NO◯ | Emphysema | YES◯ NO◯ | Mitral Valve Prolapse | YES◯ NO◯ | Fainting/Dizzy Spells | YES◯ NO◯ | Swelling of Ankles/Feet/Hands | |
| Heart Attack | YES◯ NO◯ | Bruise Easily | YES◯ NO◯ | Chemotherapy | YES◯ NO◯ | Rheumatism | YES◯ NO◯ | Heart Pacemaker | YES◯ NO◯ | | YES◯ NO◯ |
| Ulcers | YES◯ NO◯ | Rheumatic Fever | YES◯ NO◯ | Epilepsy or Seizures | YES◯ NO◯ | Hepatitis A (infect.) | YES◯ NO◯ | Recent Weight Loss | YES◯ NO◯ | Cold Sores/Fever Blisters | |
| Asthma | YES◯ NO◯ | Glaucoma | YES◯ NO◯ | Blood Disease | YES◯ NO◯ | Herpes | YES◯ NO◯ | AIDS | YES◯ NO◯ | | YES◯ NO◯ |

Do you have any disease, condition, or medical problem not listed above?

If yes, please list: _____

Kenneth L. Andow
D D S • P C
*A lifetime of healthy smiles for your entire family*

# OFFICE AND FINANCIAL GUIDELINES

Thank you for selecting our office for your dental care. In an effort to keep your dental costs down while maintaining the highest level of professional care, the following guidelines have been established.

## GENERAL INFORMATION

Your customized treatment plan will be outlined and financial obligations discussed. If treatment is delayed, this initial plan may vary. Quoted fees are the best estimate for the discussed treatment and are guaranteed for 45 days. Because the sequence of your treatment is extremely critical, your appointments will be reserved exclusively for you.

We have established the following methods of payment for your use:

1. Cash or Check
2. Visa, MasterCard, Discover and American Express
3. CareCredit Financing

Your dental care is not complete until your financial obligations are met. A $30 fee will be charged to your account for any returned check. Any costs and fees incurred in an effort to enforce payment shall be your responsibility.

## YOUR DENTAL BENEFIT

Most likely, your employer (or past employer) is providing you with a dental reimbursement plan. As such, your dental coverage is a contract between you and your insurance company. You will always receive quicker responses, quicker payments and better payments if you contact your insurance company directly with specific questions.

As a courtesy to you, we will do our best to help you get the maximum benefit possible from your provider. Today, dental insurance is not designed to cover all the cost of dental care but is used to help offset the cost of care.

Most importantly, we will do everything we can to help you achieve that healthy, beautiful smile you deserve.

## PRIVACY STATEMENT

Any personal information you provide us including general, health and financial information will be held in strict confidence. All detailed guidelines are in our Notice of Privacy Practices.

## REFERRALS

If you are satisfied and appreciate the dental care you are receiving from our office, please tell your family, friends and co-workers about us. Our greatest reward is knowing that you are pleased with the services we provide.

---

By signing below, I certify that I have read and understand the above. I also acknowledge receiving a copy of this office's Notice of Privacy Practices.

| | |
|---|---|
| _____ | _____ |
| Print name | Date |
| _____ | _____ |
| Signature (or parent, if minor) | Witness |