Dr. Jared Kearschner DDS
Dr. Jenny Kearschner DDS

Artistry • Integrity • Passion

WWW.KEARSCHNERFAMILYDENTISTRY.COM
Tel 812-883-4160
1101 North Jim Day rd Suite 113
Salem, Indiana 47167

PATIENT INFORMATION

Date: ☐ New Patient ☐ Update

Patient: ______ Last ______ First ______ MI ______ Preferred ______ Title

☐ Male ☐ Female ☐ Child* ☐ Student** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

*If Child, provide parent/guardian name(s) below:

______ Parent/Guardian Name(s)

**If Student, please complete: ☐ Full-time ☐ Part-Time

______ School/Location

Patient Date of Birth: ______ Patient SSN: ______

Address: ______ Address Line 1

______ Address Line 2

______ City ______ ST ______ Zip Code

Home: ______
Cell: ______
Other: ______
Pager: ______
Fax: ______

E-Mail: ______

Referral? ☐ Yes ☐ No Referred by: ______

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

______ Name ______ Relationship Tel: ______

EMPLOYMENT INFORMATION

Employer: ______ Occupation: ______

Address: ______ Address Line 1

______ Address Line 2

______ City ______ ST ______ Zip Code

Work: ______ X ______
Direct: ______
Other: ______
Pager: ______
Fax: ______

E-Mail: ______

DENTAL INSURANCE INFORMATION

Subscriber: ______ Last ______ First ______ MI ______ Preferred ______ Title

Subscriber Date of Birth: ______ Subscriber SSN: ______

Subscriber Employer: ______

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ______

Primary Dental Insurance: ______

Group/Policy No.: ______ ID No.: ______

Address: ______

______

______ City ______ ST ______ Zip Code

Tel: ______
Toll-free: ______
Fax: ______

Secondary Insurance Carrier: ______

Subscriber Name: ______ ID No.: ______ DOB: ______

Address: ______

______

______ City ______ ST ______ Zip Code

Tel: ______
Toll-free: ______
Fax: ______

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PREVIOUS DENTIST INFORMATION

Dentist: ______________________ Telephone: ______________________

Clinic/Facility: ______________________

Address: ______________________

____
CITY ST ZIP CODE

Reason for changing: ______________________

DENTAL HISTORY

ORAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Date of Last Dental Visit: ______________________ Treatment Type: ______________________

☐Y☐N Are you currently having dental discomfort? If yes, explain: ______________________
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: ______________________
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: ______________________
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Have missing teeth been replaced?
☐Y☐N Orthodontic appliances now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you want to become a regular continuing care patient in our practice?
☐Y☐N Do you want your mouth properly restored and pain free?
☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:
____

The most important concerns regarding my dental treatment are:
____

What factors are most important for your satisfaction with our office?
____

Any additional concerns/comments?
____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (Thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)
____
☐Y☐N Any unusual speech habits? If yes, explain: ______________________
☐Y☐N Any lost teeth? If yes, list: ______________________
☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?
____

PRIMARY PHYSICIAN INFORMATION

Physician: ______________________ Telephone: ______________________

Clinic/Facility: ______________________

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MEDICAL HISTORY

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

☐Y☐N Under a physician's care now?
What is your preferred Pharmacy? ______
☐Y☐N Any serious illnesses/surgeries? ______
☐Y☐N Use tobacco in any form? If Yes, Type: ______
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: ______

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:
______

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:
______

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ALZHEIMER
☐ ADHD
☐ AIDS/HIV
☐ ANEMIA/ANGINA
☐ ARTHRITIS/ GOUT
☐ ANXIETY
☐ ARTIFICIAL HEART VALVE
☐ ARTIFICIAL JOINTS
☐ ANAPHYLAXIS
☐ ASTHMA
☐ AUTISM/ASPERGER'S
☐ BLOOD TRANSFUSION/DISEASE
☐ BREATHING PROBLEMS
☐ BRUISE EASILY
☐ CANCER/CHEMOTHERAPY
☐ CHEMICAL DEPENDENCY
☐ CHEST PAINS/ CONGENITAL HEART DISORDER
☐ DRUG ADDICTION
☐ EASILY WINDED
☐ DIABETES
☐ DIZZINESS/FAINTING
☐ EPILEPSY/SEIZURES
☐ FREQUENT EAR INFECTIONS
☐ FREQUENT HEADACHES
☐ HEARING PROBLEMS
☐ HEART ATTACK
☐ HEART DISEASE
☐ HEART MURMUR
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE
☐ KIDNEY DISEASE
☐ LIVER PROBLEMS
☐ MITRAL VALVE PROLAPSE
☐ MONONUCLEOSIS
☐ PACEMAKER
☐ OTHER – PLEASE LIST: ______
☐ PSYCHIATRIC TREATMENT
☐ RADIATION/CHEMO
☐ RESPIRATORY DISEASE
☐ RHEUMATIC FEVER
☐ SINUS PROBLEMS
☐ STROKE
☐ THYROID CONDITION
☐ TUBERCULOSIS
☐ ULCERS
☐ VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ASPIRIN
☐ ANESTHETIC – LOCAL
☐ BARBITURATES
☐ OTHER – PLEASE LIST: ______
☐ CODEINE
☐ DAIRY
☐ LATEX
☐ LACTOSE INTOLERANCE
☐ METAL SENSITIVITY
☐ NITROUS OXIDE SEDATION
☐ SLEEPING PILLS
☐ SULFA DRUGS
☐ PENICILLIN/OTHER ANTIBIOTICS

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS
☐ BLOOD THINNERS
☐ INSULIN
☐ OTHER DIABETIC MEDICATIONS
☐ OTHER (PLEASE LIST BELOW)
☐ ANTIHISTAMINES/ALLERGY
☐ CANCER/CHEMO MEDICATIONS
☐ NITROGLYCERIN
☐ RECREATIONAL DRUGS
☐ DAILY ASPIRIN
☐ CORTISONE/STEROIDS
☐ ORAL CONTRACEPTIVES
☐ THYROID MEDICATIONS
☐ BLOOD PRESSURE MEDICATIONS
☐ HEART MEDICATION/DIGITALIS
☐ OSTEOPOROSIS MEDICATIONS
☐ TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

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Reviewed by DR.____

Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept most major dental insurance; however, we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar. **No estimate is a guarantee of payment. Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.**

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail. I hereby authorize payment directly to Dr. Kearschner the dental benefits otherwise payable to me. I hereby authorize Kearschner Family Dentistry to release any information concerning my health or dental care, advice, treatment, or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals**. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered**. **Workers Compensation claims** will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. Any amount not covered by the carrier, will be your responsibility.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.
- **Payment Information**
    - All major credit cards are accepted (Visa, MasterCard, American Express & Discover)
    - Various financing options with personal finance company, CareCredit and Prosper Healthcare Lending.
  - Minors must be accompanied by a parent or legal guardian. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

All Payments are DUE Date of Service, Balances over 90 days will be turned over to a collection agency. The Balance MUST be paid in full before you can be seen again in our office and all future visits must be paid at time of scheduling.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Be aware that if a balance continues or you are not compliant with a payment plan legal action may be taken against you.

Short Cancelled/ Missed Appointments

- ***Please give 48 hours' notice*** *if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.*
- ***If you are more than 10 min late for your apt, you may be rescheduled to a later date and be charged a missed apt fee.***
- ***Short canceled or missed appointments may be charged a $25.00 fee, which must be paid before your next appointment.***

By signing below, I acknowledge I have read and understand the guidelines above.

Signature: ***Date:***

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES
Updated 2016

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.
I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: **Date:**

RELATIONSHIP TO PATIENT: ☐ ADULT PATIENT ☐ PARENT ☐ GUARDIAN ☐ OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

Please list below anyone you would like us to share your health information with

---

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other – please list: