Kirkwood Dental
ASSOCIATES, P.A.
WHERE SMILES NEVER END!

Price's Corner 710 Greenbank Road, Wilmington, Delaware 19808
302.994.2582 fax 302.994.5151

People's Plaza 1200 Peoples Plaza, Suite 1260, Newark, Delaware 19702
302.834.7700 fax 302.834.5325

www.kirkwooddental.com

R.R. Christy, D.M.D.
E.S. Esbitt, D.M.D.
M. D. Friedberg, D.D.S.
N.J. Punturieri, D.M.D.
A.L. Young, D.D.S.

Welcome

We would like to welcome you to our practice, and thank you for choosing Kirkwood Dental Associates to provide you services to ensure your dental health. We take pride in providing quality dental care in our friendly, family-oriented offices.

We have enclosed information about our policies and services. Also enclosed is a patient information sheet and a medical questionnaire, which you may complete and bring with you for your appointment or fax it back to one of our offices. If you have any questions, or if we could be of further assistance, please do not hesitate to call us.

We look forward to meeting you, and want to warmly welcome you to our family of patients.

Sincerely,

Kirkwood Dental Associates, P.A

Kirkwood Dental
ASSOCIATES, P.A.
WHERE SMILES NEVER END!

Patient Information & Medical History

To assist us in serving you, please complete the following form. The information provided is important to your professional dental health. If there have been any changes in your health, please let us know. If you have any questions, please feel free to ask us, we will be happy to help you complete it.

Today's Date _____ ❑ Male ❑ Female

Name _____ Age _____

Date of Birth _____ SSN# _____

Address _____

_____

City _____ State _____ Zip _____

Billing Address (if different) _____

_____

City _____ State _____ Zip _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone _____ Cell Phone _____

Work Phone _____ Extension _____

Email _____

Employer _____

Referred to us by _____

Spouse Name & Phone _____

Emergency Contact Name _____

Relationship _____ Phone _____

Primary Dental Insurance

Insurance Co. Name _____

Group # _____ Subscriber ID _____

Subscriber's Name _____

Relationship _____ Employer _____

Date of Birth _____ SSN# _____

Secondary Dental Insurance (if applicable)

Insurance Co. Name _____

Group # _____ Subscriber ID _____

Subscriber's Name _____

Relationship _____ Employer _____

Date of Birth _____ SSN# _____

Physician/Cardiologist _____

Phone _____ Date of last visit _____

Previous Dentist _____

Phone _____ Date of last visit _____

	Yes	No
Are you apprehensive about dental treatment?	❑	❑
Have you had problems with previous dental treatments?	❑	❑
Are you dissatisfied with the appearance of your teeth?	❑	❑
Do you gag easily?	❑	❑
Does food catch between your teeth?	❑	❑
Do you have difficulty chewing your food?	❑	❑

How often do you brush? _____

How often do you floss? _____

Do you avoid brushing any part of your mouth because of pain?	❑	❑

Do your gums: ❑ Bleed easily ❑ Bleed when you brush ❑ Bleed when you floss ❑ Feel swollen or tender

Have you ever noticed slow healing sores in or around your mouth?	❑	❑
Are your teeth sensitive?	❑	❑

Do you feel twinges of pain when your teeth come in contact with: ❑ Hot foods or liquids ❑ Cold foods or liquids ❑ Sweets ❑ Sours

	Yes	No
Do you wear dentures?	❑	❑
Do you take fluoride supplements?	❑	❑
Have you had trauma in the jaw?	❑	❑
Does your jaw make noise when opening or closing?	❑	❑
Do you clench or grind your teeth frequently?	❑	❑
Does it hurt when you chew or open wide to take a bite?	❑	❑
Do you have earaches or pain in the front of the ears?	❑	❑
Do you have any jaw symptoms or headaches upon awaking in the morning?	❑	❑
Have you ever been diagnosed with TMD temporomandibular (jaw) disorder?	❑	❑
Do you have pain in the face, cheeks, jaw, joints, throat, or temples?	❑	❑
Are you unable to open your mouth as far as you'd like?	❑	❑
Are you aware of an uncomfortable bite?	❑	❑

continued on back

	Yes	No
Have you ever been treated for low bone density or osteoporosis?	❑	❑
Are you taking blood thinners?	❑	❑
Do you require antibiotic premedication?	❑	❑

Are you allergic, or have you reacted adversely to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	❑	❑
Penicillin or Amoxicillin	❑	❑
Sulfa Drugs	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑
Aspirin, Acetaminophen, or Ibuprofen	❑	❑
Codeine, Demerol, or other narcotics	❑	❑
Reaction to metals	❑	❑
Latex	❑	❑
Foods such as Bananas or Peanuts	❑	❑

Other _____

Other (please check all that apply)	Yes	No
Epilepsy, Seizures, or Fainting Spells	❑	❑
Stroke(s)	❑	❑
Frequent or Severe Headaches	❑	❑
Thyroid Problems	❑	❑
Persistant Cough or Swollen Glands	❑	❑
Cancer ❑ Chemotherapy ❑ Radiation	❑	❑
Diabetes	❑	❑
Tuberculosis	❑	❑
Respiratory Disease	❑	❑
Hepatitis, Jaundice, or Liver Trouble	❑	❑
Sexually Transmitted Disease	❑	❑
HIV Positive/AIDS	❑	❑
Glaucoma	❑	❑

Do you: ❑ Drink Alcohol ❑ Smoke
❑ Have a history of drug or alcohol abuse

Are you: ❑ Taking birth control or other hormones
❑ Pregnant (expected due date _____) ❑ Nursing

Heart Problems ❑ Chest Pain ❑ Shortness of Breath ❑ Heart Murmur ❑ High Blood Pressure ❑ Low Blood Pressure ❑ Heart Valve Problem ❑ Taking Heart Medication ❑ Rheumatic Fever ❑ Pacemaker ❑ Artificial Valve

Blood Problems ❑ Abnormal Bleeding ❑ Anemia ❑ Hemophilia ❑ Easy Brusing ❑ Tranfusions ❑ Frequent Nosebleeds

Allergy Problems ❑ Hay Fever ❑ Sinus Problems ❑ Skin Rashes ❑ Taking Allergy Medication ❑ Asthma

Bone or Joint Problems ❑ Arthritis ❑ Back or Neck Pain ❑ Joint Replacement (i.e. total hip, pins, or implants) ❑ Osteoperosis

Do you have any other disease, condition, or disability not listed? _____

_____

_____

Please list any surgeries and approximate date. _____

_____

_____

Please list any prescription medications or over the counter drugs you make take, and the condition it is taken for.

_____

_____

_____

_____

_____

I have read all the information and have completed the above information. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any of the above information. I hereby authorize the release of information relating to my insurance claims and give my permission for my physician to be contacted if necessary. 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.

Patient Signature (or Guardian of Minor)_____ Date _____

Kirkwood Dental
ASSOCIATES, P.A.
WHERE SMILES NEVER END!

HIPAA, INSURANCE, RECORDS RELEASE, CONTACT CONSENT

I have received a copy of KIRKWOOD DENTAL Notice of Privacy Practices from the website

I authorize the release of any medical or dental information to my insurance company when necessary to process my claims. The authorization also permits the release of medical and dental information to Kirkwood Dental from the insurance company.

I authorize payment from the insurance company be made directly to Kirkwood Dental. If payment is made to me, I agree to pay that amount to Kirkwood Dental. I agree that if the amount paid by the insurance is insufficient to cover the bill, I will be responsible for payment of the difference and if my treatment is not covered by my insurance policy, I will be responsible for the entire amount.

If the need arises that an x-ray and/or dental records need to be sent to a specialist/referral, no fee will apply. If you request that your records be transferred, a release form will need to be signed.

In the event that the office is contacted by a family member, employer, or school office, I give the office of Kirkwood Dental permission to let them know that I am/was here.

Printed Name _____

Signature _____**Date:** _____

Kirkwood Dental
ASSOCIATES, P.A.
WHERE SMILES NEVER END!

R.R. CHRISTY, D.M.D.
E.S. ESBITT, D.M.D.
M.D. FRIEDBERG, D.D.S.
N.J. PUNTURIERI, D.M.D.
A.L. YOUNG, D.D.S.

Dear Valued Patient:

The following is the payment policy for Kirkwood Dental Associates, P.A. This policy applies to all our patients. If you have insurance coverage, our staff will discuss with you the amount your insurance carrier is estimated to pay, and the following policy applies to the part of the fee that is not covered by your insurance. Please note that if your insurance company will only send the check to you. You will be expected to pay the fees in full at the time of service, unless other arrangements have been made through our billing office.

1. Payment at the time of service.

   - Cash, check, Visa, MasterCard, Discover, AmEx, or money order may make payment.

   - Procedures, which exceed $200, will qualify for a 5% discount if the charge is paid in full when beginning the procedure (teeth whitening and Care Credit excluded).

2. Payment Plan (for fees in excess of $200)

   - Requires that one half of the charge be paid at the start of the procedure. The remaining balance to be paid in two equal monthly payments, unless other arrangements have been made through our billing office.

3. Financing through CareCredit and CapitalOne

   - The CareCredit or CapitalOne application process is between the credit provider and the patient. Kirkwood Dental will supply the paperwork and initiate the contact while you are here, but we have no other influence in the process. Approval, payment arrangements, and billing questions are handled directly by CareCredit or CapitalOne.

Thank you for your consideration and support. We appreciate your business, and want to make your dental experience as pleasant as possible.

Sincerely,

KIRKWOOD DENTAL ASSOCIATES, P.A.

Suite 1260, People's Plaza • Newark, DE 19702 • (302) 834-7700 • Fax: (302) 834-5325
710 Greenbank Road • Wilmington, DE 19808 • (302) 994-2582 • Fax: (302) 994-5151
www.kirkwooddental.com

rev. 12/16