Kelly S. Kennan, D.D.S., P.C.

1820 Sweetbay Dr, Suite #104, Salisbury, MD 21804
Phone 410-742-4339 **Fax** 410-742-4388

Welcome! Thank you for selecting our Dental Healthcare Team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

Today's date:				
About you (Confidential)				
Patient's last name: First: Middle		☐ Mr. ☐ Miss ☐ Ms. ☐ Dr. ☐ Mrs.		
Marital status (circle one) Minor/ Single/ Married/ Divorced/ Widowed/ Separated				
Soc. Sec #:	Email:	Birth date: / /	Age:	Sex: ☐ M ☐ F
Street address:	Home phone:	Cell phone:		
City:	State:	ZIP Code:	Driver's License #:	
Occupation:	Employer:	Work Phone:		
Employer Address:				
If student, name of school/college:	City:	State:	ZIP Code:	
Spouse or Parent's Name:	Spouse or Parent's Employer:			
Work Phone:	Whom May We Thank for Referring You:			
Account Information				
Person Ultimately Responsible for Bill:		Phone:		
Address (if different):		Birth Date: / /		
Soc. Sec. #:	Driver's License #:	Work Phone:		
Is this person a patient here? ☐ Yes ☐ No	Employer:	Employer Address:		
City:	State:	ZIP Code:		
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is expected at each appointment.		☐ Cash ☐ Check ☐ VISA ☐ Master Card ☐ Care Credit ☐ I wish to discuss the office's payment policy		
Insurance Information				
Primary Dental Insurance Co. Name:		Address:		
City:	State:	ZIP Code:	Phone:	
Insured's Soc. Sec #:	Group #:	Subscriber ID #:		
Subscriber's Name:	Birth Date: / /	Relationship to Patient:		
Insured's Employer:				
Secondary Insurance Co. Name (if applicable):		Address:		
City:	State	ZIP Code:	Phone:	
Insured's Soc. Sec. #:	Group #:	Subscriber ID #:		
Subscriber's Name:	Birth Date: / /	Relationship to Patient:		
Insured's Employer:				
In the Event of an Emergency				
Who should we contact?	Relation:	Phone #:		
Who is your medical doctor?		Doctor's Phone:		

Patient Name: _____ D.O.B.: _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Any health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No	☐ N/A	Explain:
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	☐ N/A	Explain:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	☐ N/A	Explain:
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	☐ N/A	Explain:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	☐ N/A	Explain:
Are you on a special diet?	☐ Yes	☐ No	☐ N/A	Explain:
Do you use tobacco?	☐ Yes	☐ No	☐ N/A	Explain:
Do you use controlled substances?	☐ Yes	☐ No	☐ N/A	Explain:

Are you…	Pregnant/Trying to get pregnant?	Nursing?	Taking oral contraceptives?
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Diseases	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/ Failure	☐ LBP	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/ Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruises Easily	☐ Fainting Spells/Dizziness	☐ HBP	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had a serious illness not listed above? ☐ Yes ☐ No ☐ N/A _____

Comments:_____

_____

_____

_____

_____

*Condition may require medication

N/A- Not Answered

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient/Parent/Guardian Date

Patient Dental History

Patient Name:			Today's Date:		
Reasons for today's visit:					
Previous Dentist (Name and Location):					
Last Dental Visit:			Last X-Rays Taken:		
How often do you brush your teeth?			How often do you floss your teeth?		
Type of toothbrush you use? ☐ Automatic ☐ Manual	☐ Hard	☐ Medium	☐ Soft	Type of toothpaste?	
Is your drinking water fluoridated?			☐ Yes	☐ No	
Do your gums bleed while brushing or flossing?			☐ Yes	☐ No	
Are your teeth sensitive to hot or cold?			☐ Yes	☐ No	
Are your teeth sensitive to sweet or sour?			☐ Yes	☐ No	
Do you feel pain in any of your teeth?			☐ Yes	☐ No	
Do you have any sores/lumps in your mouth/lips?			☐ Yes	☐ No	
Have you had any head, neck, or jaw injuries?			☐ Yes	☐ No	
Have you experienced any of the following problems with your jaw?					
Clicking? Popping?			☐ Yes ☐ Right ☐ Left	☐ No	
Pain (Joint, Ear, or side of Face?)			☐ Yes	☐ No	
Difficulty opening or closing your mouth?			☐ Yes	☐ No	
Difficulty with chewing?			☐ Yes	☐ No	
Do you bite your lips or cheeks?			☐ Yes	☐ No	
Have you noticed any loose teeth?			☐ Yes	☐ No	
Have you had any previous periodontal (gum disease) treatment?			☐ Yes	☐ No	
Have you had any difficulty with extractions in the past?			☐ Yes	☐ No	
Have you had any prolonged bleeding after any procedure?			☐ Yes	☐ No	
Do you wear dentures or partial dentures? If yes, date of placement?			☐ Yes	☐ No	
Do you wear a night guard or an orthodontic appliance?			☐ Yes	☐ No	
Have you had previous orthodontic treatment?			☐ Yes	☐ No	
Do you have frequent headaches?			☐ Yes	☐ No	
Do you clench or grind your teeth?			☐ Yes	☐ No	
Have you had previous tooth whitening treatments?			☐ Yes	☐ No	
If yes, what type?	☐ Whitening Strips	☐ Trays at home	☐ 1 hour in office treatment		
If you could change anything about your smile, what would it be?					

AUTHORIZATION AND RELEASE

I certify that I have read and answered the above questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my own or my child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered top me or my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request that my dental insurance company pay directly to the dentist for my dental services. 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 dependent's behalf.

X_____ _____

Signature of Patient/Guardian Date

X_____ _____

Signature of Doctor Date

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Office & Financial Policies

Thank you for choosing the office of Dr. Kelly S. Kennan, D.D.S., P.C. as your dental care provider. We are committed to your treatment being successful. This agreement applies to patients over the age of eighteen (18) and any other party assuming responsibility for payment of services or consenting to the services for any other person; including a minor or adult. Others acting on behalf of an incapacitated person or minor or assuming payment responsibility may be asked to provide written proof of status. Unless other arrangements have been made, patients are expected to pay for services **at the time of their appointment**. Whenever possible, an approximate fee for services will be provided to you in advance of the procedure. If you have any questions about costs, please ask; bear in mind, however, that pre-procedure estimates are merely estimates and the final amount due may vary due to complications or unanticipated procedural events.

***Our office accepts several forms of payment for dental treatment provided at this office:**

- **Cash, Personal Checks, Business Checks** (by authorized person)
- **Credit Cards or Debit Cards**: MasterCard & Visa (Courtesy Processing Fee for ALL cards will be 3%)
- **Care Credit Payment Plans**: For patients who require major dental treatment, but have no dental insurance, we do offer Care Credit Patient Payment. (Ask our receptionist for more information) -Care Credit is a revolving charge account that is easy to use and takes just minutes to apply. Care Credit: 1-800-365-8295 or www.carecredit.com.
- **Smile Club**: Our annual membership benefit plan to assist with cleanings and discounts. (For Patients with NO INSURANCE)
- **Dental Insurance**: Insurance is designed to reduce your cost **NOT** eliminate it.
  (Carefirst Traditional, Cigna PPO and GEHA: In-Network Dental Insurance)
  Patients with these coverages are expected to pay their copay for the treatment on the date of service; pre-estimated by your insurance coverage. Payments will be made to our office and if an overpayment occurs the patient's account will receive credit. If requested by the patient, a refund will be issued, but must be approved by the doctor before the refund can be issued. Refund checks will not be processed until the 15th of each month.
- **All other carriers**: Patients with coverage from other carriers will be required to make FULL payments at the appointment; this is expected at the time of service. **As a courtesy** to our patients, our office will submit a claim to the patient's insurance carrier.

***Our expectations of you as the subscriber/dependent of the policy:**
I understand that insurance forms will be submitted by this office after the procedure is done.
I agree to be responsible for and pay for any portion of the bill for services rendered **NOT** paid by my insurance company.
I agree that I am ultimately responsible for coordinating payment of insurance benefits and will cooperate with this office and the insurance company to obtain payment.
I understand that I must pay any balance due in full for the portion of services not covered by insurance or pending insurance approval, if not paid as otherwise agreed with our office. All account for services shall be subject to our written collection policy as noted below.

***Our expectations of those who do not have dental insurance:**
I understand that this agreement applies to me and that full payment is expected at the time of and when services are rendered.

Late Charges, Collection Procedures and Missed Appointments:
We trust that when you make an appointment, that you will make all the arrangements necessary to be here on time. Our schedule is by appointment only, so that we can ensure each patient a timely visit.

We ask that if you **need to cancel** or **reschedule** your appointment that you **give our office a call 48 business hours in advance or more of your scheduled appointment time, so you are not charged a fee**. **We charge a fee of $250.00 for Hygiene Appointments &/or with Dr. Kelly Kennan,** for each missed appointment &/or appointments that are not canceled or rescheduled within the strict **48 business hours** required to the office, the $250.00 fee will be added to your account balance. I understand that as a patient it is **my responsibility** to fulfill my scheduled appointment time. Keep in mind that we have blocked out a time for your appointment, when you sign you are saying that you understand that **if you are 10 minutes or later** to your scheduled appointment, then the office will need to reschedule your appointment. We ask that if you **need to cancel** or **reschedule** your appointment that you **give our office a call 48 business hours in advance or more of your scheduled appointment time, so you are not charged a fee.**

If insurance or other party payment is involved, **I authorize** the release of any information by this office related to my claim, if payment in full is not made by me at the time of service. **I agree** to pay all co-pays and deductibles at the time of service or as otherwise agreed. **I authorize** and assign payment of insurance, personal injury and other benefits otherwise payable to me directly to Dr. Kelly S. Kennan, DDS, PC, and **I agree** to pay any balance not so paid. **I agree** that a photocopy of the agreement shall be valid as the original. **I agree** as the patient/guarantor to be responsible for payment of any such copay or deductible, and/or other amounts not received by Kelly S. Kennan, DDS, from any third party source including my insurance company. When/if refunds are given to patients, there will be a fee of **3.0% withheld** if the payment to our office was made with a debit or credit card. There will be a **5% interest charge** of balances greater than 30 days past due. By utilizing a check as your form of payment, and the check is returned to us from the bank for any reason, then a "**Returned Check Fee**" of $**50.00** will be added to your account balance.

At times you may have an appointment scheduled when Dr. Kelly S. Kennan is not in the office. This is allowed through the General Supervision rule, as long as the patient has been informed, agreed to the appointment, has been seen by the dentist within 7 months for a comprehensive/periodic oral exam, x-rays were taken and reviewed.

I authorize by signing below that I have read the above stated terms. **I agree** with the stated terms and accept financial responsibility for all amounts due arising from the services provided by this office to the patient named below. As provided herein and in the foregoing office financial and insurance processing policies and agreements.

_____
Patient/Responsible Party Print Name

_____ _____
Patient/Responsible Party Signature Date

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Protecting your confidential health information is important to us.

At Dr. Kennan's office, we have always kept our dental information secure and confidential. **Notice of Privacy Practices:** This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite. It is our desire to communicate to you that we are taking the new Federal HIPAA (Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We never want you to delay treatment because you're afraid your personal health history might be unnecessarily made available to others outside of our office. **So what has changed? Why a privacy policy now? Very good questions!**

The most significant variable that has motivated the Federal Government to legally enforce the importance of privacy of health information is the rapid evolution of computer technology and its use in health care. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has changed us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines and charts.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures, and your rights, as our valuable patient.

We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment and conduction health care operations. Your health will not be used for other purposes unless we have asked for and been voluntarily given your written permission. With your approval, we may disclose your personal health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your permission. We may release your personal health information for public health if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.

How your Health Information May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies, or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluation of our staff. Some of our teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, health information may be included in training staff. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of the quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing, or credentialing activities.

Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventative and restorative care modern dentistry can provide. These may include postcards, folding postcards letters, telephone reminders, electronic reminders such as email and text messaging (unless you tell us that you don't want these reminders).

Patient Acknowledgement

Patient's Name: _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If not, we would appreciate very much your acknowledging the receipt of our policy by signing this form. We look forward to providing you quality dental care.

_____ _____

Patient/Guardian Signature **Date**