

Please complete our confidential patient registration forms with your keyboard and mouse. Please print, sign, and then mail, fax or bring the forms with you to your next appointment. Our mailing address is Kevin Kunard, DDS, 33 Fremont Lake Road Box 803 Pinedale Wy 82941. Our fax number is 307-367-3701.

Date _____

Patient's Name _____
Last First Middle

Gender (M/F) _____ Marital Status _____ Birth date _____ Social Security # _____

Address _____
Mailing Address Street Address City State Zip

Email _____ Home Phone # _____

Work Phone # _____ Work Ext # _____ Cell Phone # _____ Other _____

Name of nearest relative NOT living with you _____ Relationship _____

Full address _____ Phone # _____

Patient Employment and/or Student information

Employer Name _____ Address _____

Phone # _____ Length of employment with this employer _____ years _____ months

Full Time Student YES NO School Name _____ City _____

Have you ever considered bleaching, bonding, or braces? YES NO Would you like to know more? YES NO

Are there any chips or stains on your teeth that concern you? YES NO Would you like whiter teeth? YES NO

DENTAL HISTORY

Reason for Today's visit _____

Former Dentist _____ Address _____ Phone # _____

Date of lost dental care _____ Date of last dental X-rays _____

MEDICAL HISTORY

Physicians Name _____ Phone # _____ Date of last visit _____

Have you had any serious illness or operation? YES NO If yes, describe _____

Have you ever had a blood transfusion? YES NO If yes, give approximate dates _____

WOMEN ONLY - Are you pregnant? YES NO Nursing? YES NO Taking Birth Control Pills? YES NO

Check (x) if you have or have had **any of the following**:

- | | | | |
|--------------------------------------------------|-----------------------------------------------|------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | Describe- _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |

MEDICATIONS

List medications you are currently taking:

ALLERGIES

List any allergies you may have:

PATIENTS WITH DENTAL INSURANCE

In order for us to maximize your dental benefits on a yearly basis please do the following:

PLEASE have your insurance card ready so we can copy it for our records.

PLEASE submit a completed "Pinedale Dental Patient Questionnaire" form for each family member with signatures releasing information and assignment of benefits. We will then complete an insurance form here in our office and submit it to your insurance company electronically.

If insurance does not cover or pay the total charge of services rendered, the patient or responsible party will be responsible for **ALL UNPAID EXPENSES AT THE TIME OF SERVICE.**

BLUE CROSS - BLUE SHIELD PATIENTS: Blue Cross-Blue Shield sends payment to the patient (subscriber). We require all Blue Cross patients pay the balance due at time of service or bring in the Blue Cross check when you receive it and sign it over to us. Please sign here stating that you will bring in your Blue Cross check _____.

YOUR INSURANCE CONTRACT is between you and the insurance company and it is **YOUR** responsibility to know **YOUR** insurance policy coverage.

Any balance due over 60 days will be subject to a 1.5% monthly or (18% annual) finance charge.

THERE WILL BE A \$30.00 CHARGE ON ALL RETURNED CHECKS

**YOU WILL BE RESPONSIBLE (IF NECESSARY) FOR ALL COLLECTION
AND/OR COURT COSTS AND ATTORNEY FEES**

I have read the above insurance conditions and payment and I agree to their content.

Signature of patient, parent or guardian _____

Relationship to patient _____ Date: _____