1411 John F Kennedy Drive
Bellevue, NE 68005
Phone: 402.291.3535
E-mail: Frontdesk.kda@gmail.com
www.kennedydental.net

Dr. Jamar Anderson
Dr. Jason Carpenter
Dr. Beth Kampschnieder
Dr. Afolabi Ogunleye
Dr. Cameron Thomas

Patient Registration

First Name: ______________________________ Last: ______________________________ Middle Initial: _____

Preferred Name: __________________________ Date of Birth: ____/_____/_________ Gender: ___________

Address: ____

____

Cell Phone: ________________________ Employer: _______________________ Work Number: ____________

E-mail Address: ____ Social Security Number: _________________

Emergency Contact Name: _______________________________ Relationship: ___________________________

Emergency Contact Number: _____________________________

Insurance Information

Fill out if applicable. Please bring your insurance card with you to your appointment if you have one.

Primary

Name of Insured: ____

Date Of Birth of Insured: ____/_____/_________ Employer: __________________________________

Relation: ____ Social Security Number: ______________

Insurance Company: ______________________________________ Plan Name: __________________________

Group Number: ____ ID Number: __________________________

Secondary

Name of Insured: ____

Date Of Birth of Insured: ____/_____/_________ Employer: __________________________________

Relation: ____ Social Security Number: ______________

Insurance Company: ______________________________________ Plan Name: __________________________

Group Number: ____ ID Number: __________________________

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Medical History

Name: ____ Date of Birth: ______________

Are you currently seeing a physician regularly for reasons other than a yearly checkup? Y N

If yes, who is/are your physicians and what medical conditions are they monitoring:

____

Within the last 5 years, have you ever been hospitalized or had a major operation? Y N

If yes, please describe: ____

Do you have any of the following:

- ❑ History of Heart Attack
- ❑ High Blood Pressure
- ❑ Anaphylaxis
- ❑ Acid Reflux/GERD
- ❑ HIV Positive
- ❑ Cancer
- ❑ Cold Sores
- ❑ Drug Addiction
- ❑ Fainting Spells/Dizziness
- ❑ Liver Disease (Ex: Cirrhosis, Hepatitis)
- ❑ Osteoporosis
- ❑ Thyroid or Parathyroid Disease
- ❑ Ulcers
- ❑ History of Stroke
- ❑ Low Blood Pressure
- ❑ Breathing Problems (Ex: Asthma, Shortness of Breath, COPD, Emphysema)
- ❑ Blood Disorders (Ex: Anemia, Clotting Disorders)
- ❑ Heart Problems (Ex: Angina, Arrhythmia, Defects)
- ❑ Chemotherapy or Radiation Treatment
- ❑ Diabetes
- ❑ Epilepsy or Seizures
- ❑ Sexually Transmitted Infection (Ex: HPV, Herpes)
- ❑ Kidney Disease (Ex: Dialysis)
- ❑ Sleep Apnea
- ❑ Tuberculosis

List any of the medications you are taking, including dosages if you know them:

____

____

____

____

____

Medical History (cont) Patient Initials: ___________

Are you allergic to any of the following:

- ❑ Aspirin
- ❑ Latex
- ❑ Penicillin
- ❑ Sulfa Drugs
- ❑ Codeine
- ❑ Local Anesthetics
- ❑ Acyrlic
- ❑ Dyes found in foods (ex: Red Dye)
- ❑ Metal
- ❑ Other: ____________________ ____________________

Have you ever taken a medication that contained a bisphosphonate (commonly used for bone loss) by pill form, injection or intravenously? Examples include Fosamax, Prolia, Boniva, Actonel. Y N

If yes, please detail which medication and the dates that you took the medication:

____

Do you have an artificial heart valve or congenital heart defect that requires antibiotics prior to dental procedures? Y N

Have you had a joint replacement? Y N

If yes, which joint was replaced, when was the surgery and who is your orthopedic surgeon?

____

Do you use tobacco or nicotine products (including cigarettes, electronic cigarettes/vape pens, and/or chewing tobacco? Y N

Women, are you:

- ❑ Pregnant
- ❑ Nursing
- ❑ On contraceptives

Is there any additional information that you feel we should know about your health?

____

____

____

____

____

____

By signing this form, I acknowledge that it is complete and accurate.

Signature: ____ Date: ____________________

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Late Cancellation and Missed Appointment Policy

We understand that there are sometimes emergencies or work or family obligations; however, when you fail to keep your appointment or you cancel too close to your appointment time, we are not usually able to fill this time with another patient who is needing dental care. In order to treat all of our patients equally and fairly, we have a universal policy regarding missed appointments and late cancellations. This policy is as follows:

You are allowed two missed appointments or under 24 hour cancellations in a 12 month period:

- Upon the **first** occurrence of a missed appointment or late cancellation, we reserve the right to charge a missed appointment or late cancellation fee of $75. This will not be covered by dental insurance if you have it.
- Upon the **second** occurrence, we reserve the right to charge a missed appointment or late cancellation fee of $75 *and*
    - Require a non-refundable $50 deposit to reserve your appointment time which may be applied toward your treatment if you keep your appointment that day ***or***
    - Allow appointments to be made “same-day” where you call on a day you are available to see if there are openings in the schedule. Note: There are no guarantees that we will be able to accommodate you, but we will always try our best.

If you have more than two missed appointments or under 24 hour cancellations in a 12 month period: We may consider dismissing you as a patient from our practice due to non-compliance. If you are dismissed, we will only provide emergency dental care for 30 days while you establish care with a different office.

By signing below, you acknowledge that you have received and read this form and were given an opportunity to ask questions and have them answered:

Patient/Guardian Signature: ____ Date: ___________

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Notice of Privacy Practices

By signing this form, I give Kennedy Dental my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for other similar healthcare operations.

I have been informed that I may review the practice's Notice of Privacy Policies (available on our website www.kennedydental.net and paper copy posted in practice waiting room) for a more complete description of uses and disclosures before signing this document and any time thereafter.

I understand that Kennedy Dental has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my processed health information is used. However, I also understand that Kennedy Dental is not required to agree to the request. If Kennedy Dental agrees, they must follow the restrictions.

I understand that I may revoke consent at any time by making a request in writing, except for information already used or disclosed.

By signing this form, I acknowledge that I have read, understand and agree to the terms and conditions of the financial and insurance policy and notice of privacy practices.

Printed Name: ______________________________________

Signature: ____

Date: ____________________

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THE FINANCIAL & INSURANCE POLICIES

Thank you for choosing Kennedy Dental to be your dental care provider, we look forward to offering you and your family the best dental care available. The following is our financial policy that we expect all patients to review prior to any treatment received:

Prior to the start of any services, we will inform you of your treatment options and financial options. This will help you understand your treatment, what to anticipate in fees, and allow you time to make financial arrangements.

In general, you understand and acknowledge the following:

- **Full payment is due at the time of service, unless by previous arrangement.** For your convenience, we accept payment in the form of cash, check, credit card, or one of our financing options such as Care Credit or an in-house payment plan.
- Any estimate given to you about the cost of your treatment is not a guarantee, as conditions may change during the course of treatment. In the event of a large change in expected cost, the provider will inform you so that you may choose which option is right for you.

For Patients With Insurance:

As a courtesy, Kennedy Dental Associates will bill your insurance company. You authorize your insurance company to pay your benefits directly to Kennedy Dental Associates**.** Furthermore, you understand and acknowledge the following:

- You are fully responsible for any outstanding balance on your account
- Any balance that is not covered by insurance (e.g. co-pay, out of pocket cost, my portion) is due on the date that service is rendered, unless by previous arrangement
- Any estimate of your out of pocket costs is not a guarantee, as treatment can change during the course of treatment and it is impossible for the office to know the exact details of my insurance benefits, as they range widely from carrier to carrier and policy to policy
- It is your responsibility to be aware of your individual policy limitations and requirements

Furthermore, you also understand that if your insurance company sends payment directly to you, we request that you forward the payment to Kennedy Dental Associates within 48 hours. If you fail to send the payment and the office is forced to proceed with the collections process, you will be responsible for any cost incurred by the office to retrieve payment for treatment rendered.

By signing this form, I acknowledge that I have read, understand and agree to the terms and conditions of this financial agreement.

____ ________________________________

Patient/Parent/Guardian Signature Date