Reset Form

Email Form

Bruce A. Kanehl, D.D.S

Patient Information Form

Today's Date: _____

PATIENT INFORMATION

Name: _____ Birth Date: _____ Sex: ☐ F ☐ M

Is this your legal name? Yes If not, what is your legal name? _____

If minor, Parent or Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #_____ Home # _____ Cell # _____ Business # _____

Email: _____ Occupation: _____ Employer: _____

Whom may we thank for referring you? ☐ Family member ☐ Co Worker ☐ Friend

Or did you find us yourself? ☐ Internet ☐ Close to home/work ☐ Yellow pages ☐ Advertisement ☐ Other

Other family members seen here: _____

IN CASE OF EMERGENCY

Name of local friend or relative _____

Relationship to patient: _____ Home # _____ Cell # _____ Business # _____

I have reviewed the information in this questionnaire, and it is accurate to the best of my knowledge. I understand the importance of all the above Information and that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Patient/Guardian signature: _____ Date: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms for their submission or assist in obtaining the reimbursement from insurance companies for the patient. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office team will estimate insurance coverage to the best of their ability but the patient agrees that this is an estimate only, not a guarantee of coverage, and ultimately, the patient is wholly responsible for the payment of treatment rendered.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I agree to have any photos taken of me to be used for education and training.

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

Signature of patient, parent or guardian: _____ Date: _____

Open Medical History Form Open Dental History Form Online TMJ Questionnaire Online Sleep Apnea Questionnaire