John S. Kittrell, D.D.S. • 2600 Grove Avenue • Richmond, Virginia 23220
(804) 359-6471

PATIENT REGISTRATION AND HEALTH RECORD

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answer that requires clarification or any other information you think I should have. Thank you for your cooperation.

Patient Information (CONFIDENTIAL)

Patient # _____
Soc. Sec. # _____
Date _____

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
If Patient is a Student, Name of School / College _____ City _____ State _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party E-mail _____

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Social Security # _____ Birthdate _____
Employer _____ Work Phone _____
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

Over Please

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

City State Zip:

Email:

Home Phone:

Work Phone:

Cell Phone:

Birth Date:

Social Security No.:

Marital Status:

Primary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

Secondary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

Physician Name:

Physician Phone:

Pharmacy:

Pharmacy Phone:

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height:
For Office Use Only BP ☐ Heart Rate: ☐			Weight:

Y	N	Conditions
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	HIV+ AIDS
☐	☐	Hay Fever
☐	☐	Heart Attack

Y	N	Conditions
☐	☐	Heart Disease
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement Or Implant
☐	☐	Kidney Problems
☐	☐	Leukemia
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems

Y	N	Conditions
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Yellow Jaundice
☐	☐	Sleep Apnea
☐	☐	Cholesterol
☐	☐	

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

JOHN S. KITTRELL, D.D.S.
FAMILY & COSMETIC DENTISTRY

A Division of Central Virginia Dental Care, PLC

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may chance. If we change our Notice, you may obtain a revised copy by contacting our office or going to our website.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

By signing this form, you consent to use our and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practice and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

This HIPAA Consent was signed by: _____ _____
Signature of Patient or Guardian — Printed Name of same

Relationship to the patient (if other than patient): _____ _____
Please Print — Today's Date

Signature of practice representative: _____

Dr. John S. Kittrell Family Dentistry

Financial Policy

Thank you for choosing Dr. John Kittrell Family Dentistry as your dental health provider. We are committed to your treatment being successful. Please understand that payment of your account is part of your treatment. The following is a statement of our Financial Policy; please read and sign prior to any dental treatment.

PAYMENT IS DUE AT THE TIME OF SERVICE: WE ACCEPT CASH, CREDIT CARD (VISA, MC, AMERICAN EXPRESS, DISCOVER) DEBIT CARD AND/OR PRE-APPROVED PAYMENT PLAN. WE OFFER A 5% DISCOUNT FOR SELF PAY PATIENTS WITHOUT INSURANCE AND IF BILL IS PAID IN FULL ON DAY OF SERVICE.

INSURANCE: We may accept assignment of insurance benefits. However, all co-payments must be made at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original insurance card to copy and keep on file. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance contract. You will be responsible for these balances.

Initial _____

ADULT AND MINOR PATIENTS: Adult patients are responsible for full payment at the time of service. The adult accompanying a minor and/or the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non- emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MC (which may be kept on file), or payment by cash or check at the time of service has been verified.

Initial _____

RETURNED CHECKS: There is a $25 returned check fee on all returned checks. If a check is returned for insufficient funds, we will call your bank to verify funds for any future checks that are presented as payment on your account.

Initial _____

COLLECTION FEES: If your account is turned over to a collection agency, you will be responsible for all collection costs including court fees.

Initial _____

MISSED APPOINTMENTS: Unless an appointment is cancelled 24 hours in advance, we reserve the right to charge $25 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Initial _____

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy and I understand and agree to this financial policy.

Signature of Patient or Responsible Party: _____

Date: _____

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request appointment information, result of tests, procedures and financial information. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial or account information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. I authorize Dr. John and Matthew Kittrell's Office to release my records and any information requested to the following individuals.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____

Authorization Regarding Messages

(Please check all that apply and initial)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments. Phone #_____

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care or test results. Phone #_____

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with.

_____

Patient Name (PLEASE PRINT) _____ Date _____

Patient Signature_____

Dr. John S. Kittrell, D.D.S.

Division of CVDC, PLC

2600 Grove Avenue

Richmond, VA 23220

1 (804) 359-6471 office

Dr. John S. Kittrell D.D.S. is pleased to participate in social media outlets such as Facebook, Instagram, YouTube, Google+, etc. Through these venues, we share staff pictures, office updates, new contests, and other fun and helpful information updates that may benefit our patients. With the expressed permission of our patients, we are pleased to share posts welcoming new patients to our practice, congratulating patients completing their treatment, and posting photos of our patient's beautiful new smiles.

- o I give my consent to allow Dr. John S. Kittrell D.D.S. to post updates or photographs of me/my child on social media.

- o I do not give my consent to me/my child's information being shared on social media.

Signature of Patient or Responsible Party: _____

Date: _____