KRISTYN L. BARKER DDS
smiles by design

PATIENT REGISTRATION

**** I understand that copay is due at the time services are rendered****

initial_____

FIRST NAME_____LAST NAME_____MI_____

PREFERRED NAME_____REFERRED BY_____

Birth Date_____ Email_____

Physical Address_____

City, State, ZIP_____

Home phone _____Work Phone _____Cell Phone_____

Mailing address_____

Employer Name & Phone_____

Responsible Party if other than patient:

Name_____Relationship to patient_____

Address_____

Phone_____Birth Date_____

Preferred Pharmacy Name/Location_____

Emergency Contact_____Phone_____

Responsible Party if someone other than patient

Name_____

Address_____

Phone Home_____

Primary Ins Co _____Secondary Ins Co_____

Policy Holder_____ Policy Holder_____

Relationship to Policy Holder_____ Relationship to Policy Holder_____

Policy holder SSN_____ Policy Holder SSN_____

Policy Holder Birth Date_____ Policy Holder Birth Date_____

ID #_____ ID #_____

Group #_____ Group #_____

Time 9:09 AM | Kristyn L. Barker, D.D.S. | Date 3/28/2023

Medical and Dental History(Copy)

Patient Name: | Birth Date: | Date Created:

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had an operation?	Yes No	If yes	
Have you ever had a head or neck injury?	Yes No	If yes	
Are you taking any medications, pills or drugs?	Yes No	If yes	
Do you or have you ever taken medication for Osteoporosis?	Yes No	If yes	
Do you use chewing tobacco, e-cigs or cigarettes?	Yes No	If yes	
Do you use controlled substances?	Yes No	If yes	

Women, are you...

Pregnant/ Trying to get Pregnant	Yes No
Nursing	Yes No
Taking Oral Contraceptives	Yes No

Are you allergic or have you had an adverse reaction to any of the following?

Codeine	Yes No
Local Anesthetics	Yes No
Penicillin	Yes No
Sulfa Drugs	Yes No

Any allergies not listed above? Yes No If yes

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

Acid Reflux/Gerd	Yes No	Artificial Heart Valve	Yes No	Congenital Heart Disorder	Yes No	Frequent Cough	Yes No
High Cholesterol	Yes No	AIDS/HIV Positive	Yes No	Artificial Joint	Yes No	Diabetes	Yes No
Heart Attack/Failure	Yes No	Kidney Disease	Yes No	Psychiatric Care	Yes No	Alzheimer's Disease	Yes No
Asthma	Yes No	Drug Addiction	Yes No	Heart Pacemaker	Yes No	Liver Disease	Yes No
Radiation Treatments	Yes No	Anaphylaxis	Yes No	Autoimmune Disease	Yes No	Emphysema or COPD	Yes No
Heart Trouble/Disease	Yes No	Mitral Valve Prolapse	Yes No	Angina/Chest Pain	Yes No	Cancer/Chemotherapy	Yes No
Epilepsy/Seizures	Yes No	Hepatitis A, B or C	Yes No	Osteoporosis	Yes No	Renal Dialysis	Yes No
Arthritis/Gout	Yes No	Cold Sores/Fever Blisters	Yes No	Fainting or Dizziness	Yes No	High Blood Pressure	Yes No
Sinus Trouble	Yes No	Stroke	Yes No	Thyroid Disease	Yes No	Tonsilitis	Yes No
Tuberculosis	Yes No	Tumors/Growths	Yes No				

Have you ever had any illness not listed above? Yes No If yes

Approximately when was the date of your last dental visit? _____

What is the reason for your visit today?

Dental Exam/Cleaning	Yes No	Dental Pain	Yes No	Orthodontics	Yes No	Other	Yes No

Have you had or been recommended to have a deep clean? Yes No

Do you have any dental implants? Yes No

Do you wear a night guard or other bite appliance? Yes No

There is a $25.00 cancellation fee which will be applied to all appointments cancelled without 24-hours notice. Initial to indicate your understanding of our office policy: _____

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

Signature of Patient, Parent or Guardian:

X

Date:_____

I understand Kristyn L Barker, DDS LLC creates and maintains health and dental records as part of my complete dental care. These records contain my:

- Health History
- Radiographs
- Examination Records
- Diagnosis/Diagnoses
- Treatment recommendations and plans
- Records of previous treatment completed
- Outside correspondence received from additional providers
- Account/billing information

I have received or declined the **NOTICE OF PRIVACY PRACTICES** from Kristyn L Barker, DDS LLC. This notice explains the way in which my health/dental records are used and /or disclosed. The notice also describes my right in relation to my health/dental records.

I allow _____ access to my dental records/account.
(Family or Friend's Name)

This notice expires _____ OR when I give further notice_____
(date of expiration)

Signature of Patient/Parent/Guardian *Printed name*

Today's Date *Patient Date of Birth*

Phone number *E-mail*

FINANCIAL AGREEMENT

Thank you for choosing Dr. Braker as your dental provider! Please take a moment to read the following, initial each section, then sign and date the bottom of this form.

If applicable, insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances that are not paid within 60 days my be billed to you. Please keep statements and follow-up with your insurance carrier to ensure prompt payment. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

There will be a minimum fee of $50.00 for any checks returned as Non-Sufficient Funds (NSF).

Patient balances that go unpaid for 90 or more days may be referred to a collection company or attorney. In the event this occurs, you will be liable for the collection cost of a minimum of $25.00. Further, in the event any unpaid account balance is referred to an attorney for collection, you may also be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I understand and agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf.

I understand that I will be liable for the collection cost of a minimum of $25. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in the connection therewith.

Patient name
(printed)_____

Signature of Patient or Guardian:_____

Date_____

CANCELLATION POLICY

At Dr. Barker's office, we appreciate our patients and value your time. When you schedule an appointment, we reserve the required amount of time just for you. There is a $25.00 cancellation/rescheduling fee when you miss your scheduled appointment without giving the office 24 hours notice. You can notify us by phone, text or email. Thank you!

Patient Signature_____

Printed name_____

Date_____