SOUNDVIEW
Family Dental
Eric D. Kitts, DDS

PATIENT INFORMATION

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Today's Date: _____

Patient's Name: _____ MI: _____ Preferred Name: _____

Birth Date: _____ Patient's Social Security #: _____

Title: ◯ Mr. ◯ Mrs. ◯ Ms.

Family Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Child ◯ Other

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Mobile Phone # : _____

Email Address: _____

Employer: _____ Title: _____

Work Phone #: _____

Name of Previous DDS: _____ Date of last visit: _____

If minor:

Father: _____ Work #: _____ Mobile #: _____

Mother: _____ Work #: _____ Mobile #: _____

Spouse Name: _____

Spouse Birth date: _____ Spouse Social Security #: _____

Spouse's Employer: _____ Work # : _____

Mobile #: _____

Person Responsible for Account: _____ Birth date: _____

Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PERSON TO CONTACT IN EMERGENCY: _____

PHONE #: _____

Referred To Our Office By: _____

PLEASE CONTINUE TO THE OTHER SIDE →

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INSURANCE INFORMATION

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PRIMARY

Subscriber:_____ Birth Date:_____

Employer:_____

Insurance Company:_____

Insurance Co. Phone #: _____

Group #: _____ Insurance ID or SS#: _____

SECONDARY

Subscriber:_____ Birth Date:_____

Employer:_____

Insurance Company:_____

Insurance Co. Phone #: _____

Group #: _____ Insurance ID or SS#: _____

We will bill your dental Insurance for you, however you are personally responsible to Dr Kitts for your bill and any portion the insurance does not cover. Please note that some services may not be covered and most services are rarely covered in full. We do have a 1% per month finance charge on all balances over 90 days. Please note that in order to avoid a fee, we require a 48 hour notice for cancellations and more notice is greatly appreciated. When you make an appointment, we reserve that time just for you.

By signing this form, I consent to Dr Kitts and his staff using my protected health information to carry out treatment, bill insurance, collect payment, send records and x-rays to a referral doctor, and all other usual and customary health care operations. I authorize Dr Kitts to collect payment directly from my insurance company and I agree to pay the balance outstanding. I also authorize Dr Kitts office to mail postcard appointment reminders to my house and leave recorded appointment reminders on my phone recorder.
I have read and understand the insurance and financial policies:

Signature_____ **Date**_____

Today's Date:_____

MEDICAL HISTORY

Patient Name :_____ Date of Birth:_____

Phone #:_____ Email Address: _____

Physician:_____Phone #:_____Date of Last Physical:_____

DO YOU OR HAVE YOU EVER HAD:

1) Hospitalization for illness or surgery in last 5 years ..... Yes ◯ No ◯
2) An allergic reaction ..... Yes ◯ No ◯
3) Any allergic reaction:
   a. Aspirin ..... Yes ◯ No ◯
   b. Penicillin ..... Yes ◯ No ◯
   c. Erythromycin ..... Yes ◯ No ◯
   d. Tetracycline ..... Yes ◯ No ◯
   e. Codeine ..... Yes ◯ No ◯
   f. Sedative or sleeping pills ..... Yes ◯ No ◯
   g. Dental anesthetic ..... Yes ◯ No ◯
   h. Latex ..... Yes ◯ No ◯
   i. Metal of any type..... Yes ◯ No ◯
   j. Any other Medication ..... Yes ◯ No ◯
   _____ .
4) Blood transfusion ..... Yes ◯ No ◯
5) Hepatitis Type___Date_____ ..... Yes ◯ No ◯
6) Anemia or other blood disorders ..... Yes ◯ No ◯
7) Diabetes Type _____ ..... Yes ◯ No ◯
8) Prolonged bleeding ..... Yes ◯ No ◯
9) High blood pressure ..... Yes ◯ No ◯
10) Low blood pressure ..... Yes ◯ No ◯
11) A Stroke ..... Yes ◯ No ◯
12) Chest pains on mild exertion ..... Yes ◯ No ◯
13) Heart trouble ..... Yes ◯ No ◯
14) Heart murmur ..... Yes ◯ No ◯
15) Pacemaker ..... Yes ◯ No ◯
16) An artificial valve ..... Yes ◯ No ◯
17) Emphysema ..... Yes ◯ No ◯
18) Shortness of breath ..... Yes ◯ No ◯
19) Asthma ..... Yes ◯ No ◯
20) Hives, skin rash, hay fever ..... Yes ◯ No ◯
21) Tuberculosis ..... Yes ◯ No ◯
22) Epilepsy ..... Yes ◯ No ◯
23) Seizures ..... Yes ◯ No ◯
24) Arthritis ..... Yes ◯ No ◯
25) An artificial joint ..... Yes ◯ No ◯
26) Rheumatic fever ..... Yes ◯ No ◯
27) Scarlet fever ..... Yes ◯ No ◯
28) Kidney disease ..... Yes ◯ No ◯
29) Liver disease ..... Yes ◯ No ◯
30) Thyroid or parathyroid disorders ..... Yes ◯ No ◯
31) Abdominal ulcers ..... Yes ◯ No ◯
32) Jaundice (yellow skin and eyes) ..... Yes ◯ No ◯
33) Arteriosclerosis ..... yes ◯ No ◯
34) Emotional problems ..... Yes ◯ No ◯
35) Tension or anxiety ..... Yes ◯ No ◯
36) Tumor, growth, or cancer ..... Yes ◯ No ◯
37) Radiation treatment ..... Yes ◯ No ◯
38) Glaucoma ..... Yes ◯ No ◯
39) AIDS(Acquired Immune Deficiency) Yes ◯ No ◯
40) AIDS related diseases ..... Yes ◯ No ◯
41) Herpes ..... Yes ◯ No ◯
42) History of drug or alcohol abuse ..... Yes ◯ No ◯

ARE YOU:

1) Being treated for an illness ..... Yes ◯ No ◯
2) Now taking any medication ..... Yes ◯ No ◯
3) Aware of change in health ..... Yes ◯ No ◯
4) Often thirsty ..... Yes ◯ No ◯
5) Often exhausted and fatigued ..... Yes ◯ No ◯
6) Subject to frequent headaches ..... Yes ◯ No ◯
7) Smoker, or any other tobacco ..... Yes ◯ No ◯
8) Generally a nervous person ..... Yes ◯ No ◯
9) Unhappy or depressed ..... Yes ◯ No ◯
10) Taking any naturopathic meds ..... Yes ◯ No ◯

IF FEMALE, ARE YOU NOW:

1) Pregnant or nursing ..... Yes ◯ No ◯
2) Taking birth control or hormones ..... Yes ◯ No ◯

DENTAL HISTORY

1) Are you dissatisfied with the appearance of your teeth? ..... Yes ◯ No ◯
2) Do you have sensitive teeth? ..... Yes ◯ No ◯
3) Do you now have bleeding gums? ..... Yes ◯ No ◯
4) Have you been told you have periodontal disease? ..... Ye ◯ No ◯
5) Difficulty in opening your mouth? ..... Yes ◯ No ◯
6) Sore spots or growths in mouth? ..... Yes ◯ No ◯
7) Prolonged bleeding after extraction? Ye ◯ No ◯
8) Do you grind your teeth? ..... Yes ◯ No ◯
9) Do you wear a Night Guard? ..... Yes ◯ No ◯

10) Do you snore? Yes ○ No ○
11) Do you have sleep apnea? Yes ○ No ○
12) Stress or anxiety at the dentist? Yes ○ No ○
13) Experience TMJ problems? Yes ○ No ○

PLEASE EXPLAIN FULLY IF YOU HAVE ANSWERED YES TO ANY PREVIOUS QUESTIONS

LIST OF MEDICATIONS (INCLUDING OVER THE COUNTER MEDICATIONS & SUPPLEMENTS)

Name: _____ **Dose:**_____ **Name:** _____ **Dose:**_____

Name: _____ **Dose:**_____ **Name:** _____ **Dose:**_____

Name: _____ **Dose:**_____ **Name:** _____ **Dose:**_____

Name: _____ **Dose:**_____ **Name:** _____ **Dose:**_____

Name: _____ **Dose:**_____ **Name:** _____ **Dose:**_____

IF THERE IS ANY CHANGE IN MY MEDICAL HISTORY, I WILL NOTIFY MY DENTIST

Patients Signature_____ **Today's Date**_____

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME:_____ **PHONE NUMBER:**_____

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Family Dental
Eric D. Kitts, DDS

Authorization to Release Dental Records

I, (print patient or guardian name) _____ herby authorize the release of my dental records to:

Soundview Family Dental
Dr. Eric Kitts, DDS
201 5th Ave South Suite 103
Edmonds, WA 98020
P: 425-563-6360 F: 425-563-6366
soundviewdental@gmail.com

Signature: _____ **Date:** _____

Printed Name: _____

Patient Name: _____ **Date of Birth:** _____

Address: _____

_____

Phone Number: _____

Previous Dentist: _____

Office Address: _____

_____

Phone Number: _____ **Fax Number:** _____

Reason for Release: _____

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201 5th AVENUE SOUTH SUITE 103
EDMONDS, WA 98020
P 425.563.6360
F 425.563.6366

NOTICE OF PRIVACY PRACTICES

We keep record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information.

By my signature below I acknowledge receipt of Notice of Privacy Practices.

_____ _____

Patient's name Date

_____

Patient or legally authorized individual's signature

_____ _____

Printed name if signed on behalf of patient Relationship

I authorize you to share medical information with the following people:

_____ _____

May we leave detailed messages regarding your health or dental treatment on your home or cell phone? ◯ Yes ◯ No

This form will be retained in your medical record