James K. Kramer, D.M.D., P.A.
13 S. Main Street
Selbyville, DE 19975

(302)436-5133 jkdmd@mchsi.com

Have you ever had any of the following? (check all boxes that apply):

- ☐ Heart Problems
- ☐ Heart Murmur or Mitral Valve Prolapse
- ☐ Diabetes
- ☐ Cancer
- ☐ Latex Allergy
- ☐ General Allergies
- ☐ High Blood Pressure
- ☐ Smoking/Tobacco Products
- ☐ Epilepsy
- ☐ Pregnant (currently)
- ☐ Nervous Problems
- ☐ Rheumatic Fever
- ☐ Back Problems
- ☐ Headaches
- ☐ Chronic Diarrhea
- ☐ Special Diet
- ☐ Sinus Problems
- ☐ Veneral disease
- ☐ Osteoporosis
- ☐ Artificial Heart Valves or Joints (what & when)
- ☐ Allergies to Medicine or Drugs (list below)
- ☐ Cholesterol
- ☐ Stroke
- ☐ Allergy to Anesthetics
- ☐ Pacemaker or Defibrillator
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Circulatory Problems
- ☐ Blood Disease
- ☐ Hemophilia
- ☐ Recent Weight Loss
- ☐ Psychiatric Care
- ☐ Arthritis
- ☐ Swollen Neck Glands
- ☐ Ulcer
- ☐ Chemical Dependency
- ☐ "AIDS" or Other Immunosuppressive Disorders

Is there anything else we should know about your medical history? Please print.

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Physician's and/or specialist(s) Name & speciality	Phone	Date of Last Physical

Are you under the care of a physician?

◯ Yes ◯ No

If yes, please explain: (please print)

Who may we thank for referring you?

Medications: list NAME, AMOUNT (dosage), and REASON for medication. Include ALL supplements and over the counter medicines. (please print)

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Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Employer

_____

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.All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.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 or assist in making collections form insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

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, or within five (5) days of billing, if credit shall be extended. 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 authorize the doctor and appropriate staff to take radiographs, photographs, video tapes or study models and use, if needed, for displays, presentations, or publications of the doctor including the practice website.I authorize the doctor and dental hygienist to apply fluoride to my child's teeth and take radiographs as deemed necessary.

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

Signature _____ Date_____
Relationship to patient.

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EMERGENCY CONTACT

PHONE NUMBER

MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal Government privacy rules implemented throuth the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of Dr. James K. Kramer to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that thes rules may be waived.

_____I DO NOT authorize Dr. James K. Kramer to release any or all information concerning my medical care to any individual except as set forth above.

_____I authorize Dr. James K. Kramer to verbally/written to release any or all information concerning my medical care to the following individuals.

Name Relationship to Patient

Name Relationship to Patient

Patient Signature Date

Print Patient Name Date of Birth

Response Date: