Michael A. Kail, DDS

Manor Oak Plaza
1910 Cochran Road
Pittsburgh, PA 15220
(412) 343-7855

Robinson Professional Building
5458 Steubenville Pike
Robinson, PA 15136
(412) 787-1442

Date _____

Last Name _____ First Name _____ Middle Initial _____

Social Security # _____ Date of Birth _____ Age _____

Street Address _____City _____ State____ Zipcode _____

Phone #s: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Marital Status: S M W D SE

Emergency Contact_____ (_____)_____ Relationship _____

Complete if Patient is a Minor:

Father's Name _____ DOB _____

Mother's Name_____ DOB _____

MEDICAL INSURANCE INFORMATION

Subscriber's Name _____ DOB _____ Relationship _____

Insurance Company Name _____ Subscriber SSN_____

ID Number _____ Group Number _____

Employer _____

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ DOB _____ Relationship _____

Insurance Company Name _____ Subscriber SSN_____

ID Number _____ Group Number _____

Employer _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I _____ acknowledge that I have had an opportunity to review a Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice, as it occurs.

I certify that I have read and fully understand the above statement.

*X*_____ *X*_____

Patient Signature *Date:*

The above consent is given on the patient's behalf by *(if patient is a minor)*

_____ _____

Signature of legally authorized representative *Date:*

_____

Relationship to patient

I authorize Dr. Michael A. Kail to bill my insurance carrier, automobile insurance if related to a motor vehicle accident or workers compensation if related to an on the job injury. I assign to Dr. Michael A. Kail all rights to insurance payments or other benefits to which I may be entitled for the services rendered by Dr. Michael A. Kail.

I authorize Dr. Michael A. Kail to release copies of medical records and/or other information in connection with my hospitalization or service which may include information concerning, AIDS, Human Immunodeficiency Virus (HIV) related information, mental health/mental retardation and/or drug/alcohol abuse during this period of time which is necessary for the purpose of obtaining payment for my insurer, other payers, government agencies or their designees, for the extent action has been taken prior to any expressed action to revoke this statement. The validity of this authorization to release medical records will extend one year.

I agree that my social security number can be released in conjunction with the medical device registration act.

I hereby authorize payment directly to Dr. Michael A. Kail of hospital benefits payable to me, including major medical insurance payment of surgical or medical benefits directly to attending physician but not to exceed regular charges for these services. I understand that I am financially responsible to the hospital and physician for charges not covered by this agreement or my healthcare provider. I authorize the refund of overpaid insurance benefits where my coverage is subject to a coordination of benefits.

Patient Signature: X_____**Date:**_____

Parent / Guardian Signature:_____Date:_____
(If patient is a minor)

Health History

What is your general state of health? _____

Who is your Primary Care Physician? _____Phone No _____

Who is your Dentist? _____ Phone No._____

Who referred you to our office? _____ Phone No._____

Pharmacy _____Phone No._____

WHY ARE YOU HERE TODAY? _____

Are you taking any Blood Thinners (ie Coumadin, Aspirin, Motrin, Vitamin E, Herbal Supplements)
ÿYes ÿNo List_____

Do you have any drug allergies?
ÿYes ÿNo List: _____

Are you allergic to Latex? ÿ Yes ÿ No

Do you Require Pre-Medication (ie MVP, Rheumatic Fever, Heart Murmur, or Prosthetic joints)?

ÿYes ÿ No List_____

Have you ever used recreational or street drugs (ie cocaine)? **ÿYes ÿ No** Do you consume alcoholic beverages? **ÿYes ÿNo**

Do you smoke or chew tobacco? **ÿYes ÿNo** if so, how often _____ how much _____

Do you have any of the following? *(Please check each box)*

Epilepsy or Seizures	ÿYes	ÿ No	Fainting or Dizziness	ÿYes	ÿ No	Nervousness	ÿYes	ÿ No
Stroke	ÿYes	ÿ No	Glaucoma	ÿYes	ÿ No	Cold Sores (herpes)	ÿYes	ÿ No
Persistent Cough	ÿYes	ÿ No	Emphysema	ÿYes	ÿ No	Tuberculosis/PPD	ÿYes	ÿ No
Asthma	ÿYes	ÿ No	Sickle cell disease	ÿYes	ÿ No	Hemophilia	ÿYes	ÿ No
Steroid Medication	ÿYes	ÿ No	Kidney Problems	ÿYes	ÿ No	Congenital heart lesion	ÿYes	ÿ No
Diabetes	ÿYes	ÿ No	Thyroid Disease	ÿYes	ÿ No	Heart Problems/Angina	ÿYes	ÿ No
Hypertension (High BP)	ÿYes	ÿ No	Arthritis	ÿYes	ÿ No	Heart Murmur	ÿYes	ÿ No
Bruise/Bleed Easily	ÿYes	ÿ No	Painful joints	ÿYes	ÿ No	Heart Surgery	ÿYes	ÿ No
Prosthetic heart valves	ÿYes	ÿ No	Ulcers	ÿYes	ÿ No	Mitral Valve Prolapse	ÿYes	ÿ No
Liver Disease	ÿYes	ÿ No	Hepatitis Type ____	ÿYes	ÿ No	Pacemaker	ÿYes	ÿ No
Yellow Jaundice	ÿYes	ÿ No	Blood Transfusion	ÿYes	ÿ No	Rheumatic Fever	ÿYes	ÿ No

Cancer/radiation therapy ÿYes ÿ No AIDS/HTLV-III ÿYes ÿ No Prosthetic joints ÿYes ÿ No

Alcoholism ÿYes ÿ No Hepatitis Type _____ ÿYes ÿ No Drug Addiction ÿYes ÿ No

Other _____ **Are you currently or possibly could be Pregnant?** **ÿYes** **ÿNo**

Medication List

•Medication: _____

Dosage:_____ How often:_____

•Medication:_____

Dosage:_____ How often:_____

•Medication:_____

Dosage:_____ How often:_____

•Medication:_____

Dosage:_____ How often:_____

•Medication:_____

Dosage:_____ How often:_____

•Medication:_____

Dosage:_____ How often:_____

•Medication:_____

Dosage:_____ How often:_____

•Medication:_____

Dosage:_____ How often:_____

•Medication:_____

Dosage:_____ How often:_____

•Medication:_____

Dosage:_____ How often:_____