Paul J. Kramer & James K. Kramer

www.drjameskramer.com info@kramerdmd.com

13 S. Main Street | P.O. Box 348 • Selbyville, DE 19975 (302)436-5133

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

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

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

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)

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

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

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

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Employer

As a condition of your treatment by this office, 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, must be paid for in full at the time that 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 and will send a claim for possible reimbursement to the patient. 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's examination.

In consideration for the professional services rendered to me, or at the 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. 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.

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

_____

_____

Patient Signature Date

_____

_____

_____

Response Date: _____