Kaminski DENTAL CENTER
Your smile starts here

Name:_____

Date Of Birth:_____

*Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:*

Are you under a physician's care?

☐ Yes ☐ No

If yes, please explain

Have you ever been hospitalized or had a major operation?

☐ Yes ☐ No

If yes, please explain

Have you ever had a serious head or neck injury?

If yes, please explain

☐ Yes ☐ No

Are you taking any medications? (pills, drugs, natural substances)

☐ Yes ☐ No

If yes, please list all medications:

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

Other:

Have you been hospitalized for any surgical operation or serious illness within the past 5 years?

If yes, please explain: ☐ Yes ☐ No

Are you self-confident about smiling or ever put your hand over our mouth when you smile? ☐ Yes ☐ No
When you look at your smile in the mirror, do you see any defects in your teeth or gums? ☐ Yes ☐ No
Are your teeth too long or too short? _____
Do you have large spaces between, or too much crowding of your teeth? _____
If you could make a change about your smile – what would that be: _____
What has prevented you from moving forward in making the change to your smile? _____

When opening your mouth (like yawning) do you have: ☐ Difficulty ☐ Pain ☐ Both ☐ None
Does your jaw get: ☐ Stuck ☐ Locked ☐ Go out of joint ☐ None
When chewing, talking or using your jaws, do you have: ☐ Difficulty ☐ Pain ☐ Both ☐ None
Are you aware of any noises in the jaw joint? ☐ Yes ☐ No
Do you have pain in or about the ears, temples or cheeks? ☐ Yes ☐No
Does your bite feel uncomfortable or unusual? ☐ Yes ☐ No
Do you have frequent headaches? ☐ Yes ☐ No
Have you had a recent injury to your head, neck or jaw? ☐ Yes ☐ No
Have you previously been treated for a jaw joint problem? ☐ Yes ☐ No
If so, when:

Height: _____ Weight: _____

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

| | | |
|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Alzheimer | ☐ Anemia |
| ☐ Angina | ☐ Arthritis/Gout | ☐ Artificial Heart Valve |
| ☐ Artificial Joint | ☐ Asthma | ☐ Blood Disease |
| ☐ Breathing Problem | ☐ Bruise Easily | ☐ Cancer |
| ☐ Chemotherapy | ☐ Chest Pains | ☐ Cold Sores |
| ☐ Congenital Heart Disorder | ☐ Convulsions | ☐ Diabetic |
| ☐ Drug Addiction | ☐ Emphysema | ☐ Epilepsy or Seizures |
| ☐ Excessive Bleeding | ☐ Fainting Spells | ☐ Glaucoma |
| ☐ Heart Attack/Failure | ☐ Heart Murmur | ☐ Heart Pacemaker |
| ☐ Hemophilia | ☐ Hepatitis A | ☐ Hepatitis B or C |
| ☐ Herpes | ☐ High Blood Pressure | ☐ High Cholesterol |
| ☐ Hives or Rash | ☐ Kidney Problems | ☐ Leukemia |
| ☐ Liver Disease | ☐ Low Blood Pressure | ☐ Lung Disease |
| ☐ Mitral Valve Prolapse | ☐ Osteoporosis | ☐ Pain in Jaw Joints |
| ☐ Psychiatric Care | ☐ Radiation Treatments | ☐ Recent Weight Loss |
| ☐ Renal Dialysis | ☐ Rheumatic Fever | ☐ Scarlet Fever |
| ☐ Sickle Cell Disease | ☐ Sinus Trouble | ☐ Stomach/Intestinal Disease |
| ☐ Stroke | ☐ Swelling of Limbs | ☐ Shingles |
| ☐ Thyroid Disease | ☐ Tonsillitis | ☐ Tuberculosis |
| ☐ Tumors or Growths | ☐ Ulcers | ☐ Jaundice |

☐ Any other serious illness not listed above:

_____

_____

_____

_____

_____

_____

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. It is my responsibility to inform the dental office of any changes in medical status. The signature verifies I understand and agree.

_____ _____

Signature of Patient or Parent/Guardian Date

Updated: I've reviewed the above information and all changes (if any) were made in red/dated.

_____ _____

Signature of Patient or Parent/Guardian Date

_____ _____

Signature of Patient or Parent/Guardian Date

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# PRACTICE GUIDELINES

Patient Name/ Date of Birth: _____

**HIPAA – Patient Consent:**

Kaminski Dental abides by the following HIPAA guidelines set by the government:
By checking each box in front of the line item – the patient understands and confirms the consent.

☐ Reminders of upcoming schedule appointment may be left on voice mails or with a family member, and/or a post card may be sent to your household to confirm a schedule appointment or needed appointment.
☐ Protected health information may be disclosed or used for treatment, payment or health care options

☐ The practice has a "Notice of Privacy Practices" and the patient has the opportunity to review this notice.

☐ The patient may revoke this Consent in writing at any time.

☐ Notification regarding the availability of diagnosis, pathology or laboratory results may be left on your voice mail Or with a family member (results will be left to anyone other than the patient or a family member listed below)

_____ _____
Signature of Patient or Parent/Guardian Date

Consent was signed by: (print your name) _____

**Authorization for Disclosure of Health Records**

I am authorizing disclosure of any of my health records tot eh following people:

_____

_____

_____

_____

_____

_____

**The following are internal guidelines set in place by the practice. Your signature is required at the bottom of the form in order to be seen by any of our providers. Please read each section and check of each box in front of the section confirming you have read it and agree with each statement.**

☐ Payments for service is due at the time services are provided unless other payment arrangements have been approved in advance. We accept cash, check, and most credit cards. We will be happy to process your insurance claim form for you. If you have insurance, please be prepared to pay your estimated portion of your total treatment fee on the day of service.
☐ Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

☐ Dental insurance is not meant to be a pay-all: it is only meant to be an aid. Many routine dental service are not covered by dental insurance at all. If you should have any questions regarding your coverage, you should contact your employer regarding the details of the plan it is contracted on your behalf. It is your responsibility to know your insurance coverage.

☐ Many plans tell you, you will be covered "100%". In spite of what you are told we have found that most plans only cover approximately 80% of an average fee. It has been our experience that some insurance companies tell their customers that "fee are above the usual and customary" rather than saying "the benefits are low".

☐ We must emphasize that as dental care providers, our relationship is with you NOT your insurance company. While the filing of all insurance claims is a courtesy, we extend to our patients, all charges are your responsibility.

☐ Scheduled Appointments: When we schedule an appointment for you, it is time we reserve for you exclusively. If there are any changes to our schedule that will affect your appointment, we will do our best to give you advance notice and ask if this is going to remain suitable to your schedule. We ask that you value your schedule time as well. If you need to change an appointment, we appreciate a minimum of 48 hours notice. A $50 charge may be applied to your account, if less notice is given or an appointment is missed. We understand that circumstances out of your control may arrive and for this reason, we will take that into consideration.

**If you have any questions about the above information are uncertain regarding insurance information, please do not hesitate to ask us. We are here to help you.**

**Authorization and Release:**

**I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to their party payors and or health practitioners.**
**I authorize and request my insurance company to pay directly to our office.**
**I understand that my dental insurance carrier may pay less than the actual bill for services.**
**I agree to be responsible for payment of all services rendered on my behalf or my dependents.**
**I fully understand that if my account is delinquent and is forced over to collections, I will be responsible for ALL Collection and any Attorney FEES.**

_____ _____

Signature of Patient or Parent/Guardian Date