Welcome to Kaminski Dental Center!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help!

Patient Information (CONFIDENTIAL)

Today's Date_____

Full name_____

I prefer to be called _____ Birthdate _____

Please check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced

Home Street Address _____ City _____State/Zip_____

Home Phone# _____ Cell Phone# _____

Employer _____ Work Phone# _____

E-Mail_____

How would you like to be confirmed for your appointment? ☐ Phone Call ☐ E-mail ☐ Text Message

If text message, what number do we have permission to send to? _____

How did you hear about us?

☐ Mailer ☐ Facebook ☐ Google/Website ☐ Insurance Company

☐ Referred By (Name)_____ ☐ Other_____

Emergency Contacts:

Name _____ Phone #_____ Relationship:_____

Name _____Phone #_____ Relationship:_____

Responsible Party

(If self, please just write "self" below. No need to rewrite above information)

Name of person responsible for this account_____

Relationship to Patient _____ Home Phone# _____

Cell Phone #_____ E-Mail _____

Home Street Address _____ City _____State/Zip_____

Patient's Medical History

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 may have, or medication 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 now**? ☐ Yes ☐ No

If yes, who _____

Have you ever been **hospitalized** or had a **major operation**? ☐ Yes ☐ No

If yes, when and for what _____

Have you ever had a serious **head or neck injury**? ☐ Yes ☐ No

If yes, when _____

Do you take, or have you taken, **Phen-Fen** or **Redux**? ☐ Yes ☐ No

Do you take, or have you taken, **Fosamax** *(Boniva)*, or any other **bisphosphonate**? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No ☐ Former **If yes**, how often _____

Do you use controlled substances? ☐ Yes ☐ No ☐ Former **If yes**, how often _____

Do you have, or have you ever had, any of the following? *If so please check the corresponding box*.

- ☐ AIDS/HIV
- ☐ Acid Reflux
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
  - Type_____
- ☐ Artificial Heart Valve
- ☐ Artificial Joint(s)
  - Joint_____
  - Doctor_____
  - Hospital_____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
  - Type_____
  - Remission or Active
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Colitis/Crohns Disease
- ☐ Congenital Heart Disorder
- ☐ Diabetes
  - Type_____
- ☐ Difficulty Breathing
- ☐ Emphysema/COPD
- ☐ Epilepsy or Seizures
  - Last Episode_____
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack/Failure
- ☐ Heart Surgery
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ HPV
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Problems
  - Been on Dialysis? Y N
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Pacemaker
  - Date Placed_____
- ☐ Parathyroid Disease
- ☐ Radiation Treatments
- ☐ Rheumatism
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

If you marked yes to any of the above conditions, please list details below (what kind, how long ago, what stage, etc.), or if you have had any other serious illness not listed above, please list below.

_____

_____

_____

Are you taking any **prescription medications**, **over-the-counter** medications, **herba**l drugs, and/or **vitamins**?

Please list ALL that you are currently taking: _____

_____

_____

Are you allergic or have you ever had any reactions to the following? *(check those that apply)*

- ☐ Aspirin
- ☐ Penicillin or other Antibiotics
- ☐ Codeine
- ☐ Other (please specify) _____
- ☐ Acrylic
- ☐ Any Metal
- ☐ Latex
- ☐ Barbiturates
- ☐ Sedatives
- ☐ Local Anesthetics
- ☐ Sulfa Drugs
- ☐ Hay Fever

Women: Are you ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives

If yes, what contraceptive?_____

Patient's Dental History

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, tipped, or shifting teeth
- ☐ Dry mouth
- ☐ Bad breath or bad taste in your mouth

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

- ☐ Dentures
- ☐ Partial Denture
- ☐ Orthodontic Treatment (Braces)
- ☐ Periodontal Disease (gum treatments)

If you could change your smile, you would:

- ☐ Make it whiter
- ☐ Make it straighter
- ☐ Close spaces
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

Have you ever had reactions/concerns with local anesthetic? ☐ Yes ☐ No

If yes, what was your reaction?_____

Reason for seeking care with Kaminski Dental Center?_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize to have photographs of my face, jaws, and teeth taken. I understand that these items will be used as a record of my care, and may be used for educational purposes. I further understand that if these items are used in any publication or as part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs

Signature of Patient, Parent, or Guardian Date

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 not 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 to the 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 $150.00 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