Welcome to The Dentists' Office

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 you 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)

Date______

NAME______ Birthdate______ Home Phone______

Address______ City______ State/Zip______

Email (optional)______ Cell Phone______ Soc. Sec. #______

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Employer______ Work Phone______

Business Address______ City______ State/Zip______

Spouse or Parent/Guardian's Name______ Work Phone______

Spouse or Parent/Guardian's Employer______ City______

Whom May We Thank for Referring You?______

Person to Contact in Case of Emergency (living in same home)______ Phone______

Person to Contact in Case of Emergency (not living in same home)______ Phone______

Responsible Party

Name of Person Responsible for this Account______ Relationship to Patient______

Address______ Home Phone______

Email (optional)______ Cell Phone______

Driver's License #______ Birthdate______ SSN______

Employer______ Work Phone______

Is this person currently a patient in our office? ☐ Yes ☐ No Are there other family members? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer:

☐ Cash ☐ Personal Check Credit Card: ☐ VISA ☐ MasterCard ☐ Care Credit

Insurance Information

Name of Insured______ Relationship to Patient______

Birthdate______ SSN______ DateEmployed______

Name of Employer______ Union or Local #______ Work Phone______

Address of Employer______ City______ State/Zip______

Insurance Company______ Group #______ Policy ID #______

Insurance Co. Address______ City______ State/Zip______

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured______ Relationship to Patient______

Birthdate______ SSN______ Date Employed______

Name of Employer______ Union or Local #______ Work Phone______

Address of Employer______ City______ State/Zip______

Insurance Company______ Group #______ Policy ID #______

Insurance Co. Address______ City______ State/Zip______

Patient's Medical History

Patient's Name ____

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.

Question				
Are you under a physician's care now?	○ Yes	○ No	○ N/A	______
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	○ N/A	______
Have you ever had a serious head or neck injury?	○ Yes	○ No	○ N/A	______
Are you taking any medication, pills, or prescription drugs?	○ Yes	○ No	○ N/A	______
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	○ N/A	______
Are you on a special diet?	○ Yes	○ No	○ N/A	______
Do you use tobacco?	○ Yes	○ No	○ N/A	______
Do you use controlled substances?	○ Yes	○ No	○ N/A	______

Women: Are you ☐ Pregnant or Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Local Anesthetics ☐ Other (Please specify) ______________________________

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problems	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

*Condition may require medication. N/A – Not answered by patient

Have you ever had any serious illness not listed above? Yes NO N/A If yes, please specify ______________

Comments: ____

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 and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. 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 also 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 a 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

DENTAL HISTORY

NAME: ______________________________

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
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following:
- ☐ Dentures
- ☐ Partial denture
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:
- ☐ Your last cleaning ____/____
- ☐ Your last oral cancer screening ____/____
- ☐ Your last complete X-rays ____/____

***Name of Previous Dentist*:**

____

City: __________________ State:_________

Phone Number: (___)___________________

***General Anesthesia Questions:* (required)**

Height: ____________ Weight: ____________

Have you ever had any unusual reactions or complications to medications or anesthesia?

☐ Yes ☐ No ***Is yes, please explain below:***

____

____

____

Are you interested in whiter teeth?

☐ Yes ☐ No ☐ I would like more information.

Do you smoke or use chewing tobacco?

☐ Yes How Much ___________

How Long ___________

☐ No

If you could change your smile, you would:
- ☐ Make it brighter
- ☐ Make it straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

One a scale of 1-10 with 10 the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

____

____

What is the most important thing to you about your dental visit?

____

____

EMERGENCY CONTACT NOT RESIDING WITH YOU:

Name: ______________________________

Relationship: ___________________________

Phone No. :____________________________

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 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