PATIENT INFORMATION

Date: _____ ☐ New Patient ☐ Update

Patient: _____
Last First MI Preferred

☐ Male ☐ Female ☐ Child* ☐ Student** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

*If child, provide Parent/Guardian name(s) below:

_____
Parent/Guardian Name(s)

**If student, please complete: ☐ Full-Time ☐ Part-Time

_____
School/Location

Patient Date of Birth: _____ Patient SSN: _____

Address: _____
Address Line1

_____
Address line 2

_____
City State ZIP Code

E-Mail: _____

Work: _____
Cell: _____
Other: _____
Pager: _____
FAX: _____

Referral? ☐ YES ☐ NO Referred by: _____

Emergency Information

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ Telephone: _____
Name Relationship

Insurance Information

Subscriber: _____
Last First MI Preferred

Subscriber Date of Birth: _____ Subscriber SSN: _____

Subscriber Employer: _____

Patient Relationship to subscriber:
☐ Self ☐ Spouse ☐ Child ☐ Other

Primary Insurance Carrier: _____

Group / Policy No.: _____ ID No.: _____

Address: _____
Address Line1

_____
Address line 2

_____
City State ZIP Code

Tel: _____
Toll-Free: _____
FAX: _____

Secondary Insurance Carrier: _____

Group / Policy No.: _____ ID No.: _____

Address: _____
Address Line1

_____
Address line 2

_____
City State ZIP Code

Tel: _____
Toll-Free: _____
FAX: _____

Employment Information

Employer _____ Occupation: _____

Address: _____
Address Line1

_____
Address line 2

_____
City *State* *ZIP Code*

E-Mail: _____

Work: _____

Cell: _____

Other: _____

Pager: _____

FAX: _____

Previous Dentist Information

Dentist: _____ Telephone: _____

Address: _____

_____
City *State* *ZIP Code*

Reason for changing: _____

Dental History

Oral Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of Last Dental Visit: _____ Treatment Type: _____

☐ Y ☐ N Are you currently having dental discomfort? If yes, explain: _____
☐ Y ☐ N Any unhappy / unpleasant dental experiences? If yes, explain: _____
☐ Y ☐ N Any injuries to mouth/teeth/head? If yes, explain: _____
☐ Y ☐ N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐ Y ☐ N Have missing teeth been replaced?
☐ Y ☐ N Orthodontic appliances now or in the past?
☐ Y ☐ N Gums bleed when brushing or flossing?
☐ Y ☐ N Concerned about gum disease? History of gum disease? ☐ Y ☐ N
☐ Y ☐ N Any concerns about the appearance of your teeth?
☐ Y ☐ N Does it hurt to bite or chew?
☐ Y ☐ N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐ Y ☐ N
☐ Y ☐ N Do you want to become a regular continuing care patient in our practice?
☐ Y ☐ N Do you want your mouth properly restored and pain free?
☐ Y ☐ N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are: _____

What factors are the most important for your satisfaction with our office? _____

Any comments: _____

Child/Minor parents please answer the following questions:

☐ Y ☐ N Any mouth habits (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

_____

☐ Y ☐ N Any unusual speech habits? If yes, explaun: _____
☐ Y ☐ N Any lost teeth? If yes, list: _____
☐ Y ☐ N Does the patient receive assistance with brushing and flossing? If yes, how often?

_____

Primary Physician Information

Physician: _____ Telephone: _____

Clinic / Facility: _____

Medical History

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ Y ☐ N Under a physician's care now?
☐ Y ☐ N Any hospitalization in the past 5 years? _____
☐ Y ☐ N Any serious illnes/surgeries? _____
☐ Y ☐ N Use tobacco in any form? If yes, type: _____
☐ Y ☐ N Is pre-medication required before dental visits due to heart condition of artificial joint?
☐ Y ☐ N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the medication section.*

Female Patients: ☐ Y ☐ N Currently nursing? ☐ Y ☐ N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedure might pose a risk to you, our staff, or other patients? ☐ Y ☐ N

If yes, please describe: _____

Is there anything important about your medical condition we have not asked? ☐ Y ☐ N If yes, please describe:

_____

All patients: Do you have, or have ever had any of the following? (check all that apply):

☐ Acid Reflux	☐ Autism/Asperger's	☐ Dizziness/Fainting	☐ Kidney Disease	☐ Rheumatic Fever
☐ ADHD	☐ Bleeding Disorder	☐ Epilepsy/Seizures	☐ Liver Problems	☐ Sinus Problems
☐ AIDS	☐ Bulimia	☐ Frequent Ear Infections	☐ Mitral Valve Prolapse	☐ Stroke
☐ Anemia	☐ Cancer/Malignancy	☐ Frequent Headaches	☐ Mononucleosis	☐ Thyroid Condition
☐ Anorexia	☐ Cerebral Palsy	☐ Hearing Problems	☐ Pacemaker	☐ Tuberculosis
☐ Artificial Heart Valve	☐ Chemical Dependency	☐ Heart Attack	☐ Psychiatric Treatment	☐ Ulcers
☐ Artificial Joints	☐ Chicken Pox	☐ Heart Murmur	☐ Radiation/Chemo	☐ Veneral Disease
☐ Arthritis	☐ Convulsions	☐ Hepatitis	☐ Respiratory Disease	
☐ Asthma	☐ Diabetes	☐ High Blood Preassure	☐ Other - please list _____	

All patients: Are you ALLERGIC to or have you ever had any reaction to the following? (Check all that apply):

☐ Aspirin	☐ Codeine	☐ Lactose Intolerance	☐ Sleeping Pills	☐ Other: _____
☐ Anesthetic - Local	☐ Diary	☐ Metal Sensitivity	☐ Sulfa Drugs	_____
☐ Barbiturates	☐ Latex	☐ Nitrous Oxide Sedation	☐ Penicillin/Antibiotics	_____

Medication Information

All patients: Are you currently taking any of the following? (check all that apply):

☐ Antibiotics/Sulfa Drugs	☐ Antihistamines/Allergy	☐ Daily Aspirin	☐ Blood Pressure Medications
☐ Blood Thinners	☐ Cancer/Chemo Medications	☐ Cortisone/Steroids	☐ Heart Medication /Dgitals
☐ Insulin	☐ Nitrogliceryn	☐ Oral Contraceptives	☐ Osteoporosis Medications
☐ Other Diabetic Medications	☐ Recreational Drugs	☐ Thyroid Medications	☐ Tranquilizers

☐ Other (please list below) _____

Drug Name	Dosage	Reason Prescribed

Financial Guidelines

We are commited to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **We are only accepting PPO insurance plans** _____ *Initial*
- It is the patient's responsibility to know and understand their insurance coverage. Many insurance companies are excluding-certain dental procedures or downgrading procedures to a lesser reimbursement level. Please understand, that we do our best to keep our patients updated with their insurance coverage but **NO ESTIMATE IS A GUARANTEE OF PAYMENT.** Patients are responsible for all charges not paid by your insurance. _____ *Initial*
- **Minors must be accompanied by a parent or legal guardian.** If the parents are separated or divorced, the person accompany-ing the minor will be responsible for co-payment at the time of service.

Payments

- **Payment portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made
- **Payment Information:**
  - Credit cards are accepted (Visa, MasterCard, Discover)
  - Various financing options with Care Credit® 0% for 6 or 12 months
- **Balances left over 90 days** may be turned over to our collection agency if alternative payments have been made.

Short Cancelled / Missed Appointments

WE REQUIRE 24 HOUR NOTICE FOR ANY CANCELLATION.
A $100 FEE WILL BE CHARGED TO YOUR ACCOUNT FOR FAILURE TO COMPLY.

_____ *Initial*

By signing below I acknowledge that I have read and understand the guidelines above.

Signature _____ Date: _____

Patient Consent - Payment Authorization - Signature on File

To the best of my knowledge, all of the preceeding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I herby authorize Dr. Kusz Dental Center fo the dental benefits otherwise payable to me.

I hereby authorize Dr. Kusz Dental Center to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered.

By signing below I acknowledge that I have read and understand the statements mentioned above.

Signature _____ Date: _____

Print Name: _____

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices.

I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____ Date: _____

Print Name: _____

Relationship to Patient: ☐ Adult Patient ☐ Parent ☐ Guardian ☐ Other

Please list any dependent children under the age of 18 also covered by this acknowledgement:

_____

_____

_____

☐ I give permission for the following communication to be used by Dr. Kusz Dental Center:
☐ Cell Phone ☐ Text Message Reminders Permitted ☐ Work ☐ Email ☐ Home Phone

☐ I am granting permission for Dr. Kusz Dental Center to disclose their identity to anyone who may answer my home, work or cell phone

☐ I am granting permission for Dr. Kusz Dental Center to leave a message with any person who may answer my phone or on my voicemail of the following numbers:
☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None - Please just ask for a call back
☐ Other _____

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed below:

_____

_____

_____

For Office Use Only

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign ☐ Communication barriers ☐ Emergency situation

☐ Other - please list: _____