



Welcome

Name: _____
Last First MI Title
Preferred Name: _____ Male Female
Address: _____ City _____ State _____ ZIP _____
SSN: _____ DOB: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail Address: _____
Employer: _____ Occupation: _____
Marital Status: Single Married Divorced Widowed Separated Domestic Partner
How did you hear about our office? _____
Do you prefer to be contacted for appointment confirmation via e-mail or phone? _____ (Please circle preference)

■ Insurance – Primary ■

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ Group Number: _____

■ Insurance – Secondary ■

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ Group Number: _____

■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to your practice all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____
Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____



Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Physician's Phone: _____

Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you use tobacco in any form? Yes No

Have you had any artificial joints, metal rods, pins or implants placed? Yes No

Are you taking any medications? Yes No

Please list each one: _____

Have you ever had any surgical procedures? Yes No

Please list each one: _____

- | Yes | No | Conditions |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Facial Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches |

- | Yes | No | Conditions |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV+ AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis C |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles |

- | Yes | No | Conditions |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |

- | Yes | No | Allergies |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline |

- | Yes | No | If Female, Please Answer |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking Birth Control Pills? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?
If so, # of Weeks _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing? |

Nearest relative not living with you:

Name: _____ Relationship: _____

Address: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____



Dental History

How may we help you today? _____

Your current dental health is: Good Fair Poor

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) Yes No

Are you under stress? (new job,moving,relationships) Yes No

Do you like your smile? Yes No

Is there anything you would like to change about your smile? Yes No

Are you happy with the color of your teeth? Yes No

Do your gums bleed? Yes No

How many times a do you: floss/week? _____ brush/day? _____

Are your teeth sensitive to hot, cold or anything else? Yes No

Have you lost any teeth? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Have you ever had any unfavorable dental experiences? Yes No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at Dentistry by Dr. Kaplansky we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Teeth Whitening

Dental Implants

Invisalign

Traditional Orthodontics (Braces)

Smile Makeover

Cosmetic Bonding

Sealants

Bridges

Crowns

Partial Dentures

Night/Sport Guards

Complete Dentures

BISPHOSPHONATE DRUG UPDATE

Patient's name

Date

Please, let us know if you currently take or have taken in the past (either orally or through IV) any of the following drugs, they are often prescribed for Osteoporosis, Cancer, or Paget's disease, if the answer is YES, please circle the medication:

Actonel (Risedronate)

Aredia (Pamidronate)

Bonefos (Clondronate)

Boniva (Ibandronate)

YES

NO

Didronel(Etidronate)

Fosamax (Alendronate)

Ostac (Clondronate)

Skelid (Tiludronate)

Zometa (Zoledronic Acid)

Other _____

Having been treated previously with Bisphosphonate drugs you should know that there is a significant risk of future complications associated with dental treatment.

Bisphosphonate drugs appear to adversely affect the ability of bone to break down or remodel itself thereby reducing or eliminating its ordinary excellent healing capacity.

This risk is increased after surgery, especially from extraction; implant placement or other "invasive " procedures that might cause even mild trauma to bone. Osteonecrosis may result. This is a smoldering, long-term, destructive process in the jawbone that is often very difficult or impossible to eliminate.



Financial Information

Patients with Insurance:

Patients with insurance are required to pay their co-pay and deductible at the time services are rendered. We will make our best effort to properly calculate your co-pay. If we overestimate your co-pay, the excess will be refunded to you. If we underestimate your co-pay, the amount will be billed to you. As a courtesy we will process your insurance claim.

Children under 14 must be accompanied to their appointments by a parent/guardian. Minors 14 and over who come to appointments on their own must be prepared to pay the appropriate amount. If a patient does not have payment, we will not be able to treat them that day. In the case of minor children, the parent or legal guardian authorizing treatment for the child is financially responsible to this office, regardless of any separation, divorce or court agreements. We are not a party to these agreements.

NOTE: If a particular service is not covered fully, you will be responsible for the remainder of the fee. If a particular service is not covered at all, you will be responsible for the full fee. For portions not covered by insurance, you may choose from the options below.

1. Prepayment in full when scheduling your treatment by cash, check, MC, VISA, DISCOVER or AMERICAN EXPRESS
2. CARE CREDIT: Interest free plans are available to those who qualify. Several low-interest plans are also available for extensive treatment plans.

Unpaid balances:

Balances over 30 days will be assessed a 1.5% monthly late charge (18%APR). All outstanding balances over 90 days will be subject to collection by an outside agency, which may adversely affect your credit rating. Your personal financial information will be disclosed to a third party. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33.33% of the debt, and all the costs and expenses, including reasonable attorney fees, we incur in such collection efforts.

Cancellations:

The appointment made is reserved especially for you. We require a minimum of 4: hours notice for cancelled appointments. There will be a \$50 charge for missed appointments. If you miss an appointment that is an hour or longer, you will be asked to make a deposit equal to the total cost of the visit for future appointments. Patients who repeatedly cancel appointments without notice will be asked to seek care elsewhere.

Returned Checks:

A fee of \$35 will be assessed for returned checks to cover insufficient funds bank fees.

I have read the above financial and cancellation policies and agree to abide by them. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

SIGNATURE _____ **DATE** _____

A COPY OF THIS AGREEMENT WILL BE PROVIDED UPON REQUEST

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, have read a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)