We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire.

Let us make you smile
KososkiDental

PATIENT REGISTRATION

Patient Information

First Name:_____ Last Name:_____M.I.:_____

Perferred Name_____ Responsible Party (If other than patient) _____

Address: _____City/State/Zip:_____

Whom may we thank for referring you?_____

Home Phone:_____ Work Phone:_____ EXT:_____ Mobile:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ Other

Birth Date: _____ Age:_____ SSN:_____-_____-_____ Drivers Lic: _____

E-mail:_____ I would like to receive correspondences via e-mail? ☐ Yes ☐ No

Emergency Contact:_____ Phone:_____Relationship:_____

Insurance Information:

Insured Name:_____Relationship to Patient: ☐ Self ☐ Spouse/Partner ☐ Parent

If insured is other than patient: Insured Birthdate:_____ Insured SSN:_____-_____-_____

Employers Name:_____

Insurance Carrier:_____ Group Number:_____

Carrier Address:_____City,ST,Zip_____

Release:

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my health care, advice and treatment to another dentist.
- My dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of **ALL** accounts. By signing this agreement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.
- I attest to the accuracy of the information on this page.
- **I AUTHORIZE ASSIGNMENT OF BENEFITS TO MY DENTIST**

_____ _____

Patient Signature Date

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Dental Information

1. Are your teeth sensitive to heat or cold? _____ Pressure? _____ Sweets? _____
2. Do you grind or clench your teeth?_____
3. Do you have any fear of dental work?_____
4. Date of last dental visit _____ What was done at the time? _____
5. Former Dentist Name _____ City _____
6. How would you describe your current dental problem? _____
7. How do you feel about the appearance of your teeth? _____

American Dental Association - Warning Signs of Periodontal Disease

Periodontal disease is painless. It affects 75% of the population and victims are often unaware.

8. Do your gums bleed when you brush your teeth?.....____Yes ____No
9. Are your gums red, swollen, or tender?.....____Yes ____No
10. Have your gums pulled away (receded) from your teeth?.....____Yes ____No
11. Is there pus between your teeth and gums when gums are pressed?.....____Yes ____No
12. Are your permanent teeth loose or separating?.....____Yes ____No
13. Have you noticed any changes in the way your teeth fit when biting?.....____Yes ____No
14. Have you noticed any change in fit of partial dentures?.....____Yes ____No
15. Do you have persistent bad breath?.....____Yes ____No
16. Do you snore?.....____Yes ____No
17. Does anyone in your family snore?.....____Yes ____No

18. What changes would you like to see in the appearance of your smile?

_____
_____
_____
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Medical Information

1. Are you having pain or discomfort at this time?.....____Yes ____No
2. Have you been a patient in a hospital during the last two years?.....____Yes ____No
3. Are you now taking any medication or drugs?.....____Yes ____No

   If yes, please list_____

   If yes, Physician's Name_____ Phone# _____

4. Do you consume alcohol, smoke or use tobacco in any form?.....____Yes ____No

   If yes, what and how much?_____

5. Indicate which of the following you have had or have at the present. Check "Y" for yes or "N" for no to each item.

Yes	No		Yes	No		Yes	No	
____	____	Heart failure	____	____	Artificial Joints (hip, knee, etc.)	____	____	Hepatitis A (infectious)
____	____	Heart Disease or Attack	____	____	Kidney Trouble	____	____	Hepatitis B (serum)
____	____	Angina Pectoris	____	____	Ulcers	____	____	Venereal Disease
____	____	Congenital Heart Disease	____	____	Diabetes	____	____	A.I.D.S
____	____	Heart Murmur	____	____	Thyroid Problems	____	____	H.I.V. Positive
____	____	High Blood Pressure	____	____	Glaucoma	____	____	Cold Sores / Fever Blisters
____	____	Arteriosclerosis	____	____	Cancer	____	____	Blood Transfusion
____	____	Mitral Valve Prolapse	____	____	Emphysema	____	____	Hemophilia
____	____	Artificial Heart Valve	____	____	Chronic Cough	____	____	Anemia
____	____	Heart Pacemaker	____	____	Tuberculosis	____	____	Sickle Cell Disease
____	____	Heart Surgery	____	____	Asthma	____	____	Bruise Easily
____	____	Rheumatic Fever	____	____	Hay Fever	____	____	Liver Disease
____	____	Arthritis	____	____	Allergies or Hives	____	____	Yellow Jaundice
____	____	Rheumatism	____	____	Sinus Trouble	____	____	Epilepsy or Seizures
____	____	Cortisone Medicine	____	____	Radiation Therapy	____	____	Fainting or Dizzy Spells
____	____	Drug Addiction	____	____	Chemotherapy	____	____	Nervousness
____	____	Stroke	____	____	Developmentally Disabled	____	____	Tumors
____	____	Alergy to Latex	____	____	Allergy to metal (jewelry, etc…)	____	____	Other_____

6. When you walk up the stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or be cause you are very tired?.....____Yes ____No
7. Do your ankles swell during the day?.....____Yes ____No
8. Do you use more than two pills to sleep?.....____Yes ____No
9. Have you lost or gained more than ten pounds in the last year?.....____Yes ____No
10. Do you ever wake up from sleep and feel short of breath?.....____Yes ____No
11. Are you on a special diet?.....____Yes ____No
12. Do you have or have you had any disease(s), condition(s), or problem(s) not listed?.....____Yes ____No
    If yes, please list_____
13. Are you allergic to any of the following?.....____Yes ____No

    Asprin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

If yes, please explain:_____

FOR WOMEN ONLY

Are you pregnant?_____(If yes Month_____) Are you nursing?_____ Are you taking birth control _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance or benefits for which I am entitled. I will not hold my dentist or any member of staff responsible for any errors or emissions that I may have made in the completion of this form. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, at the time of service, unless other arrangements are made with the financial department.

Emergency Contact_____Phone _____

Patient Signature _____Date_____

For Office Use Only

Reviewed by_____Date_____

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NOTICE OF PRIVACY PRACTICES — Health Insurance Portability and Accountability Act (HIPAA)

To Provide Treatment
We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff. In addition, we may share your health information with physicians, referring, dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you recive in our office. We may do this with insurance forms filed for you in the mail or sent electronically.

To Conduct Health Care Operations
Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as a part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders
Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you and your family. These communications are an important part of our philosophy of partnering with our patients to ensure they receive the best preventative and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders, or email (unless you notify us in writing that you do not wish to receive these reminders.)

Abuse or Neglect
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes including under certain circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers
We may share your health information with those you notify us will be helping you with your home hygiene , treatment, medications or payment.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization at any time in writing.

_____ _____

Patient Signature Date

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Financial Policy

PAYMENT: Payment is due at the time of service. We do not accept post-dated checks. We do accept cash, personal checks (current date), major credit cards, debit cards, and third party financing through Care Credit.

INSURANCE: As a courtesy to our patients, we are happy to file your claims on your behalf. We will make every reasonable effort to collect covered amounts from your insurance company. Deductibles, co-payments, and non-covered amounts are due at the time services are rendered. All estimates quoted are based upon information provided to us by your insurance company and are estimates only and are not a guarantee of payment. The patient is ultimately responsible for all charges incurred. Insurance companies are required by law to pay claims within 30 days. After 60 days, any unpaid claims will become the responsibility of the patient. At that time outstanding amounts to insurance will be required to be paid in full by the patient. Our first and only priority is our patients and the quality of care, not the negotiation of benefits between the insurance company and your employer.

RETURNED CHECKS: All returned checks are subject to a $30.00 returned check fee. After a check has been returned, all future payments will be on a cash or credit card basis.

DELINQUENT ACCOUNTS: Accounts over 90 days past due will be handled by our collection service. The patient agrees to pay **ALL** collection costs in additional to fees for service.

CANCELLATIONS: It is the philosophy of our office to provide optimal patient care. All patients are seen by appointment only and are scheduled with the dentist or hygienist one patient at a time. This allows us to focus our efforts on caring for and treating our patients to the best of our abilities. Thus, we require a minimum of 24 hours notice for cancellations and reschedules. This is necessary to allow us adequate time to notify patients who are on a waiting list for the first available appointment. Lack of adequate notice inhibits us from offering an exceptional standard of care to our other patients. A fee of $50 per hour scheduled may be charged for failed appointments, inadequate notice of cancellation, or rescheduling of an appointment with less than 24 hours notice. We appreciate your cooperation and respect of our efforts.

I have read the above and I understand and agree to these terms regarding my treatment by J. Anthony Kososki, D.D.S. F.A.G.D

I AUTHORIZE ASSIGNMENT OF BENEFITS TO MY DENTIST

_____ _____

Patient Signature Date