KONECNYDENTISTRY
General and Cosmetic Dentistry

Health History Form

Email:	Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle		Home Phone: ( )		Business/ Cell: ( )
Address: Mailing address		City:	State:	Zip:
Occupation:	Height:	Weight:	Date Of Birth:	Sex: M F
SS# or Patient ID: Emergency Contact:	Relationship:		Home phone: ( )	CellPhone: ( )

Do you have any of the following diseases or problems? **(Check DK if you don't know the answer)**

	Yes	No	DK
Active Tuberculosis……………………………………………………	☐	☐	☐
Persistant cough greater than 3 weeks duration…………………..	☐	☐	☐
Cough that produces blood……………………………………………	☐	☐	☐
Been exposed to anyone with tuberculosis………………………..	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X)your responses.

	Yes	No	DK
Do your gums bleed when you brush or floss? …………………….	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets, or pressure?...........	☐	☐	☐
Does food or floss catch between your teeth?............................	☐	☐	☐
Is your mouth dry?..	☐	☐	☐
Have you had any periodontal (gum) treatments?.......................	☐	☐	☐
Have you ever had orthodontic (braces) treatments?....................	☐	☐	☐
Have you ever had any problems associated with previous dental treatments?..	☐	☐	☐
Is your home water supply fluoridated?......................................	☐	☐	☐
Do you drink bottled or filtered water?..	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?.............	☐	☐	☐
Do you have earaches or neck pain?..	☐	☐	☐
Do you have any clicking, popping, or discomfort in the jaw?........	☐	☐	☐
Do you brux or grind your teeth?...	☐	☐	☐
Do you have sores or ulcers in your mouth?.................................	☐	☐	☐
Do you have dentures or partials? ……………………………………	☐	☐	☐
Do you participate in active recreational activities?.......................	☐	☐	☐
Have you ever had a serious injury to your head or mouth?...........	☐	☐	☐

Date of your last dental exam: | Date of last dental xrays:

What was done at this time? | What is the reason for today's visit?

How do you feel about your smile?

Medical Information

Please mark (x) your response to indicate if you have or have not had any of the following:

	Yes	No	Dk
Are you under the care of a physician?......................................	☐	☐	☐
Physician Name: Phone: ( )			
Address/ City/ State/ Zip:			
Are you in good health?..	☐	☐	☐
Has there been any changes in your general health within the past year?..	☐	☐	☐
If yes, what condition is being treated? ____________________ ____________________			
Date of last physical exam:________________________________			
Have you had a serious illness, operation or been hospitalized in the past 5 years?...	☐	☐	☐
If yes, what was the illness or problem? ____________________ ____________________			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?...	☐	☐	☐
If so, please list all, including vitamins, natural or herbal preparations, and/or diet supplements: ____________________ ____________________ ____________________ ____________________ ____________________			
Do you wear contact lenses?...	☐	☐	☐
Joint Replacement. Have you ever had an orthopedic total joint (hip, knee elbow, finger) replacement?................................	☐	☐	☐
Date: If yes, have you had any complications?			
Are you taking or scheduled to be taking either of the medications alendronate (Fosamax) or reisedronate (Actonel) for osetoprosis or Paget's disease? …………………………………………………..	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..	☐	☐	☐
Date treatment began:____________________________________			
Do you use controlled substances (drugs)?................................	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?....................	☐	☐	☐
If so, how interested are you in stopping? (circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?...	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hrs? _______			
If Yes, how much do you typically drink in a week? ___________			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks:______________________			
Nursing? …………………………………………………………………….	☐	☐	☐
Taking Birth control pills or hormonal replacement?......................	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to: (To all yes responses, specify type of reaction.)	Yes	No	Dk
Local anesthetics …………………………………………………………			
Aspirin …………………………………………………………………………			
Penicillin or other antibiotics …………………………………………			
Explain:			
Barbiturates, sedatives, or sleeping pills ……………………………			
Sulfa drugs …………………………………………………………………			
Codeine or other narcotics ……………………………………………			
Metals ………………………………………………………………………			
Latex (rubber) ……………………………………………………………			
Iodine ………………………………………………………………………			
Hay fever / seasonal ……………………………………………………			
Animals………………………………………………………………………			
Food …………………………………………………………………………			
Other …………………………………………………………………………			

Please mark (x) your response to indicate if you have or have not had any of the following

	Yes	No	Dk
Artificial (prosthetic) heart valve ………………………………………			
Previous infective endocarditis …………………………………………			
Damaged valves in transplanted heart ………………………………			
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD ………………………………			
Repaired (completely) in last 6 months ………………			
Repaired CHD with residual defects ……………………			
Cardiovascular Disease			
Angina ………………………………………………………………………			
Arteriosclerosis ……………………………………………………………			
Congestive heart failure …………………………………………………			
Damage heart valves ……………………………………………………			
Heart attack ………………………………………………………………			
Heart murmur ……………………………………………………………			
Low blood pressure ………………………………………………………			
High blood pressure ………………………………………………………			
Other congenital heart defects …………………………………………			
Mitral valve prolaspe………………………………………………………			
Pacemaker …………………………………………………………………			
Rheumatic fever …………………………………………………………			
Rheumatic heart disease ………………………………………………			
Abnormal bleeding ………………………………………………………			
Blood transfusion …………………………………………………………			
If yes, date: _________________			
Hemophilia …………………………………………………………………			
AIDS or HIV infection ……………………………………………………			
Arthritis ………………………………………………………………………			
Autoimmune disease ……………………………………………………			
Rheumatiod arthritis ……………………………………………………			

	Yes	No	Dk
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Cancer/Chemotherapy/radiation treatment	☐	☐	☐
Chest pain upon exertion..	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastronintestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: ______________________________			
Mental health disorders	☐	☐	☐
If yes, specify: ______________________________			
Recurrent Infections	☐	☐	☐
Type of infection: ____________________________			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐
Name of physician or dentist making recommendation:	Phone:		
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐
Explain:			

NOTE: **Both Doctor and patient are encouraged to discuss any/all relevant patient health issues and or concerns prior to any treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist a his staff will rely on this information for treating me. I acknowledge that my questions,if any,about inquiries set forth above have been answered to my satisfaction. I will not hold my Dentist, or any of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of patient/ Legal Guardian: Date:

Doctor Signature: Date:

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CONSENT FOR TREATMENT

I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify this office of any change in my health or medication. I give permission for Dr. Konecny and his clinical team to take any necessary diagnostic x-rays, photos, or study models to properly enable a complete diagnosis and treatment.

CANCELLATION POLICY

We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice. We consider all of our appointments confirmed at the time that they are scheduled. We send out reminder cards to the address that you have provided, and you will also receive a courtesy call to remind you of your appointment. We ask that you review your commitments carefully before reserving time with us to minimize appointment changes.

PAYMENT POLICY

We promise all of our patients that we will reach an understanding about both fee and how that fee will be handled before you commit to an appointment. We know that this is an important consideration for you. No treatment will be performed until it has been fully explained to you and financial arrangements have been finalized.

FINANCIAL AGREEMENT

The patient, guarantor, or legally authorized representative individually obligates him/herself and guarantees prompt payment of all charges. If payment is not received within 30 days of the date of final billing, finance charges may accrue and balance may be turned over for collection. You also agree to pay any collection agency fee necessary in collecting a balance. You also consent to pay a $25.00 return check fee for each check that is returned for insufficient funds or closed accounts.

INSURANCE POLICY

As a courtesy, we will file any standard insurance you may have, at no cost to you, as long as you furnish us with the proper information. You must contact your insurance company to review what type of coverage you have and if there are any restrictions. Your dental insurance is a private contract between you and your insurance company. All efforts on our part will be made to file your insurance claims, however, it will be your responsibility to contact your insurance company to correct any problems if we do not receive payment. We are not responsible for any fees that your insurance company substitutes or if they do not pay because a pre-determination was not sent. It is your responsibility to know your policy and inform us of any such issues. Every effort is made to estimate what your insurance may pay, based on the information your insurance company provides us about your eligibility and benefits. This is not a guarantee that your insurance company will pay the estimated amount. **You will be responsible for any and all balances that the insurance does not pay.**

_______________________________________ ____________________

Patient/Guardian Signature **Date**

KONECNYDENTISTRY
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KEEP FOR YOUR RECORDS

Notice of Privacy Policy
HIPPA Compliance

We value you as a patient and provide this notice to explain that we will do the following to respect and safeguard your privacy:

1. We will never share your personal or health information with other for any reason without your consent. We will ask you to designate those persons with whom we can share your information with, and share only information necessary with designated persons.

2. We collect personal / health information from you when you are a patient under our care, including but not limited to: name, date of birth, address, contact information, social security number, dental insurance information, and potentially past dental records should it be required. We only collect the above information about you to provide you with the proper treatment and/ or diagnosis.

3. We maintain safeguards on our patients' personal information and all dental records. The information is only used as needed to provide the best care for our patients, such as for verifying insurance benefits, processing insurance claims, and dental charting. Only the staff members responsible of such things will have access to your information.

4. We may disclose information when required by law in order to respond to a subpoena, prevent fraud, or comply with an injury by a government agency.

5. When you give us a written request to do so, we will share your patient records with a new doctor you have selected.

6. When you give us written permission to do so, we will share your information with your insurance carrier in order to process claims, verify coverage, etc. In some cases it is necessary to refer patients to another specialist, in this event we would need to share your information with the new provider in the best interest of your health and the care that is needed. This will NOT be done with out your consent and complete understanding of the necessity to see another Doctor.

7. You have the right to inspect and copy your dental records. You may request to amend the information, but you DO NOT have the right to change dental record. The doctor has the final say about amending information if he disagrees with the request. You can revoke your authorization by written request at any time but not for work already processed.

8. We will update you each year on our privacy practices / policies and any changes that have occurred.

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss your care. Your PHI may be disclosed to the individuals listed below until you notify us otherwise in writing.

____ ____

____ ____

For Office Use Only

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from the patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (please provide specific details)

____

____

____

____ ____________________________

Employee Signature Date

This form does not constitute legal advice and covers only federal, not state, law.

KONECNYDENTISTRY
General and Cosmetic Dentistry

7140 Beneva Road
Sarasota, FL 34238

Patient Photo Release Form

I ______________________________________, hereby authorize Konecny Dentistry or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes including website publication, Facebook posts, before and after examples, etc.

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Please initial one option:

_____I do not mind if my photographs are used in any of the above stated situations.

_____I only agree to have my teeth shown without any identifying features.

_____I do not consent to my photograph being used in any way other than chart identification.

Signed____Date____________________

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Patient Financial Policy Agreement

Thank you for selecting Konecny Dentistry for your dental care services. We are committed to providing the highest quality of care. As a courtesy to you, if applicable, we will bill your insurance company for any services rendered. You have been/will be given a Treatment Plan Estimate detailing your estimated patient responsibility for any/all prescribed dental work. *Insurance remittance estimates are provided as a courtesy and are based on current information collected from insurance carriers*. While we would like to advise you of your exact financial obligation before your date(s) of service, the scale of different insurance plan designs make it extremely difficult. Your copayment or patient portion may vary based on actual payments made by your insurance provider. Claims for your dental care are submitted on the day treatment is completed. In the event your insurance carrier remits less than the estimated amount of the claim, for any reason inclusive of denied claims, **the patient/responsible party, is financially responsible to pay the unpaid balance**. Bills for any amount due will be sent to you upon receipt of remittance or explanation of benefits by your insurance company.

_________I agree to be financially responsible for payment of all dental services.

_________I agree to give Konecny Dentistry complete and accurate insurance information for any primary/secondary insurance coverage. I understand that failure to supply and/or complete any accurate information may result in denial of my claim or delay of insurance remittance. **I agree to pay any balance remaining on my account after my insurance claim(s) are processed.**

_________I understand my financial responsibilities as they may relate to my dental insurance plan, and understand that any insurance portion(s) not paid by my insurance company(ies) are my financial responsibility. In the event of self-pay patients, non-insurance based treatment, I understand that I will be given a treatment plan and fee estimate prior to any dental work being performed. **I understand that I will be 100% financially responsible for the cost of such treatment.**

________________________________ ____________

Patient Signature **Date**