

**DENTAL INSURANCE**

**DENTAL HISTORY**

Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dry Mouth Y N Sensitivity to cold Y N

Former Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Finger Nail Biting Y N Sensitivity to hot Y N

City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Food collection between teeth Y N Sensitivity to sweets Y N

Date of last dental visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Foreign objects Y N Sensitivity when biting Y N

Date of last dental x-rays\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grinding teeth Y N Sores/growths in mouth Y N

*Please circle “YES” or “NO” to indicate if you* Gums swollen or tender Y N How often do you floss?\_\_\_\_\_\_\_\_\_\_\_

*have had any of the following:* Jaw pain or tiredness Y N How often do you brush?\_\_\_\_\_\_\_\_\_\_

Bad breath Y N Lip or cheek biting Y N Do you have dentures or partials? Y N

Bleeding gums Y N Loose teeth or broken filling Y N How do you feel about your smile?

Blisters on lips or mouth Y N Mouth breathing Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Burning sensation on mouth Y N Mouth pain, brushing Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chew on one side of mouth Y N Orthodontic treatment Y N

Cigarette, pipe, or cigar smoking Y N Pain around ear Y N

Clicking or popping jaw Y N Periodontal treatment Y N

**PHONE NUMBERS**

Home (\_\_\_)\_\_\_\_\_\_\_\_\_\_Work (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_ Ext\_\_\_\_\_

Cell Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best time and place to reach you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 

*3*

*4*

**PATIENT INFORMATION**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex M F Age\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Married Widowed Single Minor

Separated Divorced Partnered

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Employer/School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School Phone(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*1*

*2*



 **Date**

**Name:**

**Last First**

Are you under a physician’s care now? О Yes О No If yes

Have you ever been hospitalized or О Yes О No If yes

had a major operation?

Have you ever had a serious head О Yes О No If yes

or neck injury?

Have you ever taken Fosamax, Boniva, О Yes О No If yes

Actonel or any other medications

containing Bisphosphonates?

Are you taking any medications, О Yes О No If yes

pills or drugs?

containing Bisphosphonates?

Are you on a special diet? О Yes О No

Do you use Tobacco? О Yes О No

FOR OFFICE USE ONLY

Dentist X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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f

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use controlled substances? О Yes О No If yes

**High Cholesterol О Yes О No**

**Hives or rash О Yes О No**

**Hypoglycemia О Yes О No**

**Leukemia О Yes О No**

**Liver Disease О Yes О No**

**Low Blood Pressure О Yes О No**

**Lung Disease О Yes О No**

**Mitral Valve Prolapse О Yes О No**

**Osteoporosis О Yes О No**

**Pain in Jaw Joints О Yes О No**

**Psychiatric Care О Yes О No**

**Radiation О Yes О No**

**Shingles О Yes О No**

**Sinus Trouble О Yes О No**

**Stomach Disease О Yes О No**

**Stroke О Yes О No**

**Thyroid Disease О Yes О No**

**Tuberculosis О Yes О No**

**Tumors О Yes О No**

**Diabetes О Yes О No**

**Drug Addiction О Yes О No**

**Easily Winded О Yes О No**

**Emphysema О Yes О No**

**Epilepsy/Seizures О Yes О No**

**Excessive bleeding О Yes О No**

**Excessive Thirst О Yes О No**

**Frequent Cough О Yes О No**

**Freq. Headaches О Yes О No**

**Glaucoma О Yes О No**

**Heart Attack Failure О Yes О No**

**Heart Murmur О Yes О No**

**Heart Pacemaker О Yes О No**

**Heart Trouble О Yes О No**

**Hemophillia О Yes О No**

**Hepatitis A О Yes О No**

**Hep B or C О Yes О No**

**Herpes О Yes О No**

**High blood Pressure О Yes О No**

**Aids/HIV Positive О Yes О No**

**Alzheimer’s Disease О Yes О No**

**Anaphylaxis О Yes О No**

**Anemia О Yes О No**

**Angina О Yes О No**

**Arthritis/Gout О Yes О No**

**Artificial Heart Valve О Yes О No**

**Artificial Joint О Yes О No**

**Asthma О Yes О No**

**Blood Disease О Yes О No**

**Blood Transfusion О Yes О No**

**Breathing Problems О Yes О No**

**Bruise Easily О Yes О No**

**Cancer О Yes О No**

**Chemotherapy О Yes О No**

**Chest Pains О Yes О No**

**Cold Sores О Yes О No**

**Convulsions О Yes О No**

**Cortisone Medicine О Yes О No**

Comments:

\*Women: Are you? О Nursing? О Pregnant/Trying to get pregnant? О Taking oral contraceptives?

Are you allergic to the following?

О Aspirin О Penicillin О Codeine О Acrylic О Metal О Latex О Sulfa Drug О Local Anesthetics

OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge, all of the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Update X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Update X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 This notice 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.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



CONSENT FOR TREATMENT

T

[Sidebars are great for calling out important points from your text or adding additional info for quick reference, such as a schedule.

They are typically placed on the left, right, top or bottom of the page. But you can easily drag them to any position you prefer.

When you’re ready to add your content, just click here and start typing.]

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

[Sidebars are great for calling out important points from your text or adding additional info for quick reference, such as a schedule.

They are typically placed on the left, right, top or bottom of the page. But you can easily drag them to any position you prefer.

When you’re ready to add your content, just click here and start typing.]

We reserve the right to charge for appointments cancelled or broken without 48 hours advance notice. We consider all of our appointments confirmed at the time that they are scheduled. In the event of unforeseen circumstances and you have to cancel your appointment, you can do so only by calling the office. We ask that you review your commitments carefully before reserving time with us to minimize appointment changes.

PAYMENT POLICY

[Sidebars are great for calling out important points from your text or adding additional info for quick reference, such as a schedule.

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When you’re ready to add your content, just click here and start typing.]

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.

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

FINANCIAL AGREEMENT

[Sidebars are great for calling out important points from your text or adding additional info for quick reference, such as a schedule.

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INSURANCE POLICY

[Sidebars are great for calling out important points from your text or adding additional info for quick reference, such as a schedule.

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When you’re ready to add your content, just click here and start typing.]

As a courtesy, we will file any PPO dental insurance you may have, as long as you furnish us with the proper information to submit the claim. Your dental insurance is a private contract between you and your insurance company. You must contact your insurance company to review what type of coverage you have and if there are any restrictions. As a courtesy we will file your insurance claim, however, it is your responsibility to contact your insurance company to correct any problems if we do not receive payment. 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 your insurance company does not pay after 90 days of filing your dental insurance claim.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Guardian Signature Date**