KONECNYDENTISTRY
General and Cosmetic Dentistry

1 PATIENT INFORMATION

PLEASE NOTE: FILL OUT ALL 4 PAGES ATTACHED. WHEN FINISHED, RETURN COMPLETED FORMS, ID AND INS CARD(IF APPLICABLE) TO THE FRONT DESK.

Date ______/______/__________

Patients Name____________________________________

Social Security #_______-______-_______

Address____

City____

State____________ Zip______________________

E-mail____

Sex M F Age___________

Date of Birth_______________________

Single Married Minor

Occupation_____________________________________

Patient Employer/School__________________________

Whom may we thank for referring you?

____

2 DENTAL INSURANCE

DO NOT FILL OUT IF FRONT DESK HAS THIS INFORMATION

Subscriber Name____________________________________

Relationship to patient______________________________

Insurance Company__________________________________

Date of Birth_______________________________________

Insurance ID #______________________________________

3 PHONE NUMBERS

Cell Phone (_____) __________-__________________

Home Phone (_____) __________-__________________

IN CASE OF EMERGENCY, CONTACT:

Name____

Cell Phone (_____) __________-__________________

4 DENTAL HISTORY

Reason for today's visit___________________

Former Dentist___________________________

City/State_______________________________

Date of last dental visit____________________

Date of last dental x-rays__________________

Please circle "YES" or "NO" to indicate if you have had any of the following:

Bad breath Y / N

Bleeding gums Y / N

Blisters on lips or mouth Y / N

Burning sensation on mouth Y / N

Chew on one side of mouth Y / N

Pain around ear Y / N

Clicking or popping jaw Y / N

Food collection between teeth Y / N

Foreign objects Y / N

Grinding teeth Y / N

Gums swollen or tender Y / N

Jaw pain or tiredness Y / N

Lip or cheek biting Y / N

Loose teeth or broken filling Y / N

Mouth breathing Y / N

Mouth pain, brushing Y / N

Orthodontic treatment Y / N

Periodontal treatment Y / N

Sensitivity to hot Y / N

Sensitivity to cold Y / N

Sensitivity to sweets Y / N

Sensitivity when biting Y / N

Sores/growths in mouth Y / N

How often do you floss?___________

How often do you brush?___________

Do you have dentures or partials? Y N

How do you feel about your smile?

____

____

____

KONECNY DENTISTRY
General and Cosmetic Dentistry

Are you under a physician's care now? O Yes O No If yes ____

Have you ever been hospitalized or had a **major operation**? (last 10 years) O Yes O No If yes ____

Have you ever had a serious head or neck injury? O Yes O No If yes ____

Have you ever taken medications for Bone loss? O Yes O No If yes ____

Do you take Prescribed Medications O Yes O No If yes ____

Do you use Tobacco O Yes O No

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

Are you allergic to the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Sulfa Drug

O Local Anesthetics O None

OTHER:____

Do you use controlled substances? O Yes O No **If yes please list**: ____________________________________

Aids/HIV Positive	**O Yes O No**	**Excessive bleeding**	**O Yes O No**	**Lung Disease**	**O Yes O No**
Alzheimer's Disease	**O Yes O No**	**Excessive Thirst**	**O Yes O No**	**Mitral Valve Prolapse**	**O Yes O No**
Anemia	**O Yes O No**	**Frequent Cough**	**O Yes O No**	**Osteoporosis**	**O Yes O No**
Arthritis/Gout	**O Yes O No**	**Freq. Headaches**	**O Yes O No**	**Pain in Jaw Joints**	**O Yes O No**
Artificial Heart Valve	**O Yes O No**	**Glaucoma**	**O Yes O No**	**Psychiatric Care**	**O Yes O No**
Artificial Joint	**O Yes O No**	**Heart Murmur**	**O Yes O No**	**Radiation**	**O Yes O No**
Asthma	**O Yes O No**	**Heart Pacemaker**	**O Yes O No**	**Sinus Trouble**	**O Yes O No**
Blood Disease	**O Yes O No**	**Heart Trouble**	**O Yes O No**	**Stomach Disease**	**O Yes O No**
Bruise Easily	**O Yes O No**	**Hemophillia**	**O Yes O No**	**Stroke**	**O Yes O No**
Cancer	**O Yes O No**	**Hepatitis A B or C**	**O Yes O No**	**Thyroid Disease**	**O Yes O No**
Chemotherapy	**O Yes O No**	**Herpes**	**O Yes O No**	**Tuberculosis**	**O Yes O No**
Cold Sores	**O Yes O No**	**High blood Pressure**	**O Yes O No**	**OTHER**	
Cortisone Medicine	**O Yes O No**	**High Cholesterol**	**O Yes O No**		
Diabetes	**O Yes O No**	**Hypoglycemia**	**O Yes O No**	______________________	
Drug Addiction	**O Yes O No**	**Liver Disease**	**O Yes O No**	______________________	
Epilepsy/Seizures	**O Yes O No**	**Low Blood Pressure**	**O Yes O No**	______________________	

Comments:____

____

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.

Patient X____ Date: ______/______/________

Dentist 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.

____

____

____

KONECNY DENTISTRY
General and Cosmetic Dentistry

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 records to properly enable a complete diagnosis and treatment. **I knowingly and willingly consent to any and all dental treatment from Dr. Konecny and his clinical team.**

CANCELLATION POLICY

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

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. **All payments are due at the time of service.**

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 your 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 all balances. Your insurance company has up to 30 days to pay your claim. If your claim is not paid within 30 days, you will pay the remaining balance on your account. You can correspond with your insurance company thereafter.**

____ _______/_______/_________

Patient/Guardian Signature **Date**