KOCIAN FAMILY DENTAL
YOUR HOMETOWN DENTIST

# WELCOME TO OUR PRACTICE

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely:

## Patient Information

First Name: _____Pref. Name: _____ Middle Initial: _____ Last Name: _____
Street: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Work #: _____
Cell Phone #: _____ Cell Phone Carrier: _____
Date of Birth: _____ Social Security Number: _____-_____-_____ Sex: ☐ Male ☐ Female
Email Address: _____
Emergency Contact: _____ Emergency Phone #: _____
**How did you hear about our office?** _____

## Responsible Party

Relation: _____ First Name: _____ Middle Initial: _____ Last Name: _____
Street: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Work #: _____
Cell Phone #: _____ SS #: _____-_____-_____Date of Birth: _____

## Primary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

**Subscriber Information:**

First Name: _____ Middle Initial: _____ Last Name: _____
Date of Birth: _____Subscriber SS #: _____-_____-_____
Patient Relationship to Subscriber:_____
Employer Name: _____Insurance Company: _____
Subscriber ID/Policy Number: _____Group/Contract Number: _____

## Secondary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

**Subscriber Information:**

First Name: _____ Middle Initial: _____ Last Name: _____
Date of Birth: _____Subscriber SS #: _____-_____-_____
Patient Relationship to Subscriber:_____
Employer Name: _____Insurance Company: _____
Subscriber ID/Policy Number: _____Group/Contract Number: _____

## Health History

Are you under the care of a primary physician? ☐ Yes ☐ No Date of Last Physical: _____
Primary Physician's Name: _____ Physician's Phone Number: _____

## Dental History

Reason for today's visit: _____
Date of last dental visit/cleaning: _____
Are you currently in pain: ☐ Yes ☐ No If yes please explain: _____
Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ NO
If yes please explain: _____

CONTINUED ON BACK OF FORM

Do you require antibiotics prior to dental procedures? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? ☐ No ☐ Yes

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ No ☐ Yes Interested in whitening? ☐ No ☐ Yes

Do your gums bleed? ☐ No ☐ Yes How many times a week do you floss: _____

How many times in a day do you brush? _____ Type of Bristles? ☐ Hard ☐ Medium ☐ Soft

Thank you for filling out this form completely. It will enable us to help you more effectively. I understand my information will be held in a strictest confidence and it is my responsibility to inform this office of any changes in my account or medical status. If you have any questions at any time, please feel free to ask us. We are happy to help.

## SIGNATURE AUTHORIZATION

**** I authorize the dental staff to preform any necessary dental services that I may need during diagnosis and treatment.**

****6 month appointments routinely consists of an exam, prophylaxis (cleaning), and a fluoride treatment (for all children under 16 and as recommended by Doctor otherwise). Bitewings x-rays will be taken at least once per year as recommended by Doctor, and a full mouth x-ray will be updated every three years. These are standards of care to give each patient the best service we can provide. Each employer's policy has different allowances and limitations. Since it is the patient who has the contract with the insurance it is your responsibility to know your insurance coverage. If you have any questions regarding your treatment, you must ask before treatment is rendered.**

**** I agree to be responsible to for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental insurance claims.**

**** I authorize payment of the dental benefits otherwise payable to me directly to Quality Dental Care.**

**** I understand that all payments at the time of the appointment are estimates only and I am responsible for all charges incurred on my account that are not covered by insurance. I understand that all balances on my account are due in full with in 60 days of date of service regardless of insurance payment. A service charge of 1.33% per month, 16% APR, with a minimum of $1.00 will be added to all overdue accounts. A late fee of $20.00 will be added to all accounts unpaid for 90 days. I agree to be liable for all legal and collection fees.**

**** Since appointment times are reserved just for the patient scheduled, we require 24 hours' notice to change appointments without a charge. All appointments changed with less than the required notice is subject to a $50.00 cancelation fee.**

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** I acknowledge that I have received access to the office's Notice of Privacy practices.**

**** I authorize the release of any of my dental information including proposed treatment plans, procedure fees, and dental history to the following individuals:**

- _____ Name _____ Relationship
- _____ Name _____ Relationship
- _____ Name _____ Relationship

_____
Print Patient's Name

_____
Date

_____
Signature