ZAMBROWSKI GENERAL DENTISTRY

PATIENT FORMS

First Name: ______________ Last Name: ______________ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ______________

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)

First Name: ______________ Last Name: ______________ Middle Initial: ____

Address: ______________

City: ______________ State: ________ Zip: ________

Home Phone: ________ Work Phone: ________ Cell Phone: ________

Birth Date: ________ Social Security #: ________

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

PATIENT INFORMATION

Address: ______________

City: ______________ State / Zip: ________ , ________

Home Phone: ________ Work Phone: ________ Cell Phone:

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

Birth Date: ________ Soc Sec: ________ Preferred Communication (Circle):

E-mail: ______________ CALL TEXT EMAIL

List current Medications here:

PRIMARY INSURANCE INFORMATION

IF NO DENTAL INSURANCE DRAW AN "X" THROUGH THE BOXES

Name of Insured: ______________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec # & Member ID: ______________ Insured Birth Date: ________

Patient Employer: ______________

Ins. Company: ______________

Address: ______________

City, State, Zip: ______________

SECONDARY INSURANCE INFORMATION (IF APPLIES)

Name of Insured: ______________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec & Member ID: ______________ Insured Birth Date: ________

Patient Employer: ______________

Ins. Company: ______________

Address: ______________

City, State, Zip: ______________

MEDICAL HISTORY FORM

General Questions

Question	Answer	
Are you currently under a physician's care?	○ Yes ○ No	If yes
Have you ever beeen hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you currently taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Are you currently taking or have ever taken Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes
Do you use tobacco or tobacco products?	○ Yes ○ No	If yes
Are you currently on a special diet?	○ Yes ○ No	If yes

Allergies

Are you allergic to any of the following? Check all that apply.

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Sulfa Drugs

If *NO* allergies please notate here:

____

If allergic to anything other than what is listed above please notate here: ○ Yes ○ No If yes

WOMEN ONLY

Women are you...

Question	Answer
Pregnant or trying to become pregnant?	○ Yes ○ No
Nursing?	○ Yes ○ No
Taking oral contraceptives?	○ Yes ○ No

Medical Conditions

Do currently have or have had any of the following? Check all that apply.

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxsis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis or Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easliy Winded
- ☐ Emphesemas
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ GE Reflux/Heartburn
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Disease/Trouble
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes ________

INFORMED CONSENT FOR DENTAL PROCEDURES

You, the patient, understands that I have the right to accept or reject dental treatment recommended by my dentist and acknowledge that prior to consenting to the recommended treatment by signing below, I have been fully advised of and I have carefully considered the anticipated benefits and possible known risk of the recommended procedure, alternative treatments, or the option of no treatment, as they are presented to me.

I have been advised and I understand that individual reactions to treatment cannot be predicted, and by consenting to the treatment, I am acknowledging my willingness to accept all risk and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. I understand that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, at this office or with other recommended dentist or specialist, following all pre and post treatment instruction, including oral hygiene and dietary instructions, taking prescribed medication, and reporting to this office any changes in my health status. I understand that failing to follow the advice of my dentist may increase the chance of a poor outcome.

Please read the items below, initial where indicated, and sign at the bottom of the form.

1. **Treatment to be Provided**

   I understand that during my course of treatment that the following ***MAY*** be provided:

   Examinations, Preventive Services, Restorations, Crowns and Bridges, Root Canal Therapy Extractions, Radiographs, Other

   Patient Initials_______________

2. **Drugs and Medications**
   I have been advised and I understand that antibiotics, analgesics and other medications can cause allergic reaction causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reactions). I will inform the office of any such known reactions to the best of my knowledge. I have advised the dentist of any and all medication of any type that I currently am taking, and I acknowledge that my failure to advise the dentist may have unforeseen medical consequences for me.

   Patient Initials_______________

Local Anesthesia

I understand that there are some risks in the administration of local anesthesia. Most risk are related to the position of the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur, they might include loss of, or disturbed sensation of the tongue and/or on the lip on the side of the injection. If this occurs, it is often temporary, and normal sensation usually returns in several days. However, in very rare cases, the loss of sensation may extend for a longer period or become permanent. In addition, injection of a local anesthesia into the body may result in a rare allergic reaction.

Patient Initials________________

3. **Changes in Treatment Plan**

I have been advised and I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Patient Initials_________________

4. **Insurance Communication**

I give permission to the dental office to communicate with and bill my dental insurance provider for any treatment to me, if applicable.

Patient Initials _________________

I understand that dentistry is not an exact science and that, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

Patient Signature____Date_________

FINANCIAL AGREEMENT

ACCEPTED FORMS OF PAYMENT: We accept cash, checks, VISA, MASTERCARD, & DISCOVER. We unfortunately do not accept American Express. We also offer financing through Care Credit.

> For dental treatment requiring *LAB WORK OR ANY RESTORATIVE TREATMENT* involving multiple steps (ex: crowns, bridges, root canals, dentures, or implants etc.) we ask that ½ of the fee is due at the first appointment with the remaining balance due at delivery.
>
> For dental treatment requiring a *PRE-AUTHORIZATION OF BENEFITS* (ex: crowns, bridges, root canals, dentures, or implants etc.) we ask that ½ of the fee that is not covered by your insurance be due at the first appointment with the remaining balance due at delivery.

PATIENTS WITHOUT DENTAL INSURANCE: Payment in full is expected at the time of services are rendered.

EMERGENCY/URGENT TREATMENT WITH OR WITHOUT INSURANCE: Payment in full is expected at the time of services rendered.

PATIENTS WITH DENTAL INSURANCE: As a courtesy to you we will file your insurance company. Please be advised that your agreement with your insurance carrier is a private one and that ultimately you are responsible for payment. If an insurance carrier has not paid a claim within 60 days of billing our fees are due in full and payable from you. Should our office receive a payment from your insurance after you have paid a prompt refund will be issued to you.

Most insurance companies will respond within 2-3 weeks. After your insurance pays any remaining balance is your responsibility. We will mail you a statement and payment in full is due within 21 days of receiving your statement. We do not carry account balances month to month. We ***REQUIRE*** you to pay the ***ESTIMATED*** "patient portion" at the time of service. This may include a deductible and/or an ***ESTIMATED*** percentage of each procedure.

NOTE: If your insurance reimburses the ***SUBSCRIBER (YOU)*** payment is due at the time of service.

PROMPT PAYMENT: Just as we make every effort to accommodate you when you are in need of dental care, we expect that you will make every effort to pay your bill promptly. We reserve the right to charge a $20.00 per month billing charge on all past due accounts.

Patient Name (PRINT): ______________________________ **Date:** ________________

Responsible Party Signature: ______________________ **Relationship to Patient:** ________

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I _______________________________ **(PRINT PATIENT/GUARDIAN NAME)** have received or been offered a copy of Zambrowski General Dentistry's Notice of Privacy Practices.

Signature of Patient/Representative:_______________________________ **Date**: _____________

Relationship to Patient **(circle one)**: Self Child Spouse Caregiver Parent

PATIENT INFORMATION DISCLOSURE

May we discuss details regarding your care, treatment, billing/insurance information, and appointment information with someone else other than you?

Examples: Your husband/wife, parent, child, friend, etc.

PLEASE CIRCLE: **YES** **OR** **NO**

If **YES**, you must list the name and relationship of each individual below

Name (PRINT)	**Relationship to Patient**
_____________________________	____________________________
_____________________________	____________________________
_____________________________	____________________________
_____________________________	____________________________
_____________________________	____________________________

Signature of Patient/Representative: ___________________________ **Date**: _______________

Relationship to Patient **(circle one)**: Self Child Spouse Caregiver Parent

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__An emergency situation

__ Communication barrier

__Other (Please specify): _________________________