Patient Information

Date: _____ Birth Date: _____ Social Security #:_____

Name: _____ Sex: ☐ M ☐ F

How do you prefer to be addressed by the doctor and staff? _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____Cell Phone /Pager: _____

E-mail:_____ Circle the best method to correspond w/ you: Mail, Home #, Work#, Cell #, E-mail

Patient Employed By: _____ Occupation: _____

Business Address: _____

Spouse's Name (***or*** parent's name/information if patient is minor): _____ __

Spouse Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Local Pharmacy: _____ Address:_____ Phone:_____

Primary General Dentist: _____ Other Dentist/ Specialist seen for routine care _____

Emergency contact/ phone number: _____

Dental Insurance – please provide your insurance card so we can make a photocopy

Subscriber Name: _____ Relation To Patient: _____ Birth Date: _____

Subscriber Employed By: _____ Occupation: _____ Social Security #:_____

Insurance Company: _____ Insurance Co Phone#:_____

Secondary dental insurance coverage:

Subscriber Name: _____ Relation To Patient: _____ Birth Date: _____

Subscriber Employed By: _____ Occupation: _____ Social Security #:_____

Insurance Company: _____ Insurance Co Phone#:_____

PATIENT NAME:_____
BIRTH DATE:_____

ADULT MEDICAL-DENTAL HEALTH HISTORY QUESTIONNAIRE

DATE:_____

DIRECTIONS TO THE PATIENT: The following information about your health history is very important for us to provide you with the best possible dental care in a safe way. Incorrect information may be dangerous to your health. **ALL** questions must be answered completely and accurately. If you don't understand a question, or are unsure of the answer, or want to discuss it with the dentist, circle its number or letter, This Health History Questionnaire will become a part of the patient's dental record and will be considered confidential information.

Name of Your Physician:_____ Office Telephone:_____

Address of Your Physician_____

1. Are you in good health? ..... Yes No Don't Know

2. Has there been any change in your health in the last year? ...…..... Yes No Don't Know
   If yes, explain:_____

3. Have you ever been hospitalized, had a major operation or serious illness? ..... Yes No Don't Know
   If yes, explain: _____

4. Date of your last visit to the doctor:_____ Reason for last visit:_____

_____

5. Are you currently receiving treatment or regular medical care by your doctor? ……. Yes No Don't Know
   If yes, for what condition(s)? _____
   _____

6. Are you taking any of the following medications:
   a. Antibiotics or sulfa drugs ……. Yes No Don't Know
   b. Anticoagulant (blood thinners) ……. Yes No Don't Know
   c. Medication for high blood pressure …….. Yes No Don't Know
   d. Cortisone (steroids) …….. Yes No Don't Know
   e. Tranquilizers ……. Yes No Don't Know
   f. Antihistamines ……... Yes No Don't Know
   g. Aspirin, Advil Nuprin, Motrin or Naprosyn …… Yes No Don't Know
   h.Insulin, tolbutamide (Orinase) or other drugs for diabetes ……... Yes No Don't Know
   i. Digitalis, Nitroglycerin or other drugs for heart trouble ……. Yes No Don't Know
   j. Birth control pills or other hormones …… Yes No Don't Know
   k. Synthroid or other thyroid medication …… Yes No Don't Know
   l. AZT or other drugs for HIV ……. Yes No Don't Know
   m. Bisphophanates, Fosamax, Actonel, Boniva, Zometa, Aredia (current or past ……..Yes No Don't Know
   n. Others, including vitamins, herbs, etc. please list:
   _____

7. Have you had any allergic or unusual reactions to any substance or medication? ….. Yes No Don't Know
   If yes, specify what substance/medications, and what reactions_____

HAVE YOU EVER BEEN TREATED BY A DOCTOR FOR: *(Circle your response and underline any condition(s))*

8. Damaged heart valves, artificial heart valves, heart murmur, rheumatic fever, rheumatic heart disease, congenital heart problem?…… Yes No Don't Know
9. Do you have an artificial joint?…….. Yes No Don't Know
10. Heart trouble, heart attack, high blood pressure, stroke? ……..Yes No Don't Know
    a. Do you have pain in your chest upon exertion?…… Yes No Don't Know
11. Severe or frequent headaches? Sinus Problems? …… Yes No Don't Know
12. Blood disorders such as anemia or hemophilia? ……. Yes No Don't Know
13. Breathing problems, emphysema, tuberculosis or other lung problems? …… Yes No Don't Know
14. Asthma, hay fever or hives? ……..Yes No Don't Know
15. Stomach or intestinal ulcers? …… Yes No Don't Know
16. Cancer, x-ray treatments, or chemotherapy? ……... Yes No Don't Know
17. Thyroid trouble? …….. Yes No Don't Know
18. Diabetes or blood sugar problems? ……. Yes No Don't Know
19. Hepatitis, jaundice, or liver disease? …….. Yes No Don't Know
20. Kidney infections, frequent urination, or renal (kidney) dialysis? ……. Yes No Don't Know
21. Stroke, seizures, fainting spells, numbness or other neurological problems? ……. Yes No Don't Know
22. Syphilis, gonorrhea, or genital herpes, sexually transmitted disease? ……Yes No Don't Know
23. AIDS, AIDS-related condition or HIV positive? ……Yes No Don't Know
24. Arthritis, rheumatism, autoimmune diseases (ex. lupus)?……. Yes No Don't Know
25. Phobias, anxieties, depression, psychoses, fears, or other mental problems? ……. Yes No Don't Know
26. For **women**, are you pregnant or do you think you may be pregnant? ……Yes No Don't Know
27. Are there any other problems about your health that you know of? …… Yes No Don't Know
    If yes, describe: _____

HABITS AND PERSONAL HISTORY:

28. Do you now or have you ever used recreational drugs (besides alcohol or tobacco)? … Yes No
29. How many packs of cigarettes do you smoke per day? How many years? ……. ____Packs/Day ___
    a. If you smoked in the **past,** how many packs per day did you smoke? How many years ____ Packs/Day ____
    b. If you smoked in the **past,** when did you quit?..... _____Yrs ago
    c. If you smoke, are you interested in help quitting?..... Yes No
30. How many drinks of beer, wine or liquor do you have per day? ……. ____Drinks per Day

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give my permission to the dentist to obtain from my physician or dentist, any additional information regarding my medical history needed to provide me the best dental treatment possible.

PERSON COMPLETING FORM: Signature:_____ Date:_____

If other than patient, indicate relationship:_____

Do not write below this line

SIGNATURE, ATTENDING DENTIST:___DMD, MS Date:_____

Office Information

Insurance Information

There is no direct relationship between our office and your insurance company. The type of plan chosen by you and/or your employer determines your insurance benefits; **dental insurance policies vary**. While it is your responsibility to understand your insurance policy, we will do what we can to help you understand and maximize your insurance benefits.

We ask that you be responsible for the payment of **emergency visits, examinations, consultations, biopsies, radiographs, and maintenance (cleaning) visits**. The office will submit your insurance claim so that **your insurance company may reimburse you.**

We will accept **payment directly from your primary insurance company** for other **commonly covered** periodontal treatment(s) rendered. Prior to treatment, our office will attempt to contact your insurance company to estimate/determine available benefits. This will inform our office what your insurance company is **estimating** to cover. This is only an **estimate of benefits,** and not a guarantee of payment. We suggest that you call your insurance company to verify benefits as well. **You will be responsible for payment of the balance not covered by your *primary* insurance (your co-pay) at the time treatment is rendered.** If financial arrangements for the patient's portion of the fee are necessary, they must be arranged ***prior*** to treatment. After 45 days, any unpaid balance not covered by your insurance company (including delays in insurance company payment/processing) will be billed to you and is due within 15 days.

Overdue accounts (balances due over 60 days) will be charged finance charges of 1.5% monthly (18% annually). Overdue/unpaid accounts will be subjected to collections actions. The patient or guardian will be responsible for collections agency, attorney, court and all associated fees incurred by Dr. Paul C. Kazmer, Jr., DMD, MS PA if collection actions are necessary.

Insurance/Communication Authorization/Scope of Care

I authorize the release of any information contained in my dental files for the purpose of my treatment, billing and processing of insurance claims. I permit a copy of this signature, if needed, to be used in place of the original on all my insurance submissions. In addition, I authorize release of any information contained in my dental files to the/my referring dentist(s) and/or treating dentists and /or physician(s). Also, I authorize my medical physician to release any or all information/lab work that is pertinent to my dental treatment with Dr. Kazmer. I understand that it is my responsibility to seek care with a restorative dentist who will diagnose and treat restorative and/or other dental treatment needs. My treatment with Paul C. Kazmer, Jr., DMD, MS, PA is limited to periodontal and/or dental implant concerns.

Broken Appointment Policy

Your appointment time has been reserved especially for you. If you are unable to keep your appointment, please notify us **at least 48 hours in advance.** As a courtesy to our patients we will attempt to confirm your appointment, but it is the patients (or guardians) sole responsibility to keep and confirm scheduled appointments. **Broken appointments, late arrival (more than 15 minutes after your scheduled appointment) requiring rescheduling, and appointments cancelled with less than 48 hours notice will be charged $100 per appointed hour.**

Office Fee Policy

A fee of **$25** will be charged for insufficient funds/returned checks. After examination an initial treatment plan will be established and fees will be reviewed. During treatment, unexpected situations may be discovered. The actual fee(s) charged will depend on services rendered in order to correct periodontal/other destruction/damage/ defects/disease.

I understand and agree to these office guidelines.

Signature of responsible individual:

X Date: