Name_______________________________________ Date of Birth ____________ Social Security #___________________

Address ____ City, State, Zip_______________________________________

E-mail ____ Cell # _____________________ Home #____________________

Work #/Other #_____________________ Emergency Contact ____________________ Emergency #________________

For Minors Only: Parent/Guardian Full Name ____ Date of Birth ________________

Dental Insurance ______________________ ID # ____________________ Group Name/#________________________

Subscriber Name _______________________________________ Date of Birth ______________ Relationship _________

Dental Information (Please mark and X to indicate if you have or ever had any of the following)

__ Bleeding Gums __Bad Breath/Halitosis __Blisters/Ulcers/Sores __ Dry Mouth

__Orthodontics __Partials/Dentures __Periodontal Disease __Wisdom Teeth Removal

__Sensitivity __TMJ Problems __Toothaches __ Root Canal Treatments

__Grinding/Clenching __Crown/Bridge Work __Difficulty Eating __Surgery of Mouth/Jaw

Date of last cleaning/x-rays/examination: _________________ **Previous Dentist:** ________________________________

Allergic Reactions (Please mark and X to indicate if you have or ever had any of the following)

__Aspirin __Barbiturates/Sleeping Pills __Iodine__ Local Anesthetics __Penicillin __Codeine/ Other Narcotics

__ Sulfa __ Clindamycin __Latex __ Epinephrine __Metals __ Other:_____________________________________

Medical Information (Please mark and X to indicate if you have or ever had any of the following)

Current Medications: ____ (Provide list if applicable)

Physician Name ______________________ Phone # ______________ Pharmacy ___________________ Phone # _______________

Have you been hospitalized or had surgery (within the past two years): Yes__ No__ , if yes: _______________________

Has a doctor ever told you that you need to **PREMEDICATE** before dental treatment? Yes ___ No ___ If yes, what type: _____________

Have you ever taken bisphosphonates (i.e. Fosamax, Zometa, Reclast)? Yes___ No___

Do you do any of the following: Smoking ___ Alcohol Use ___ Drug Use ___

Women only: Pregnant ___ Weeks: ______ Nursing ___ Birth control/ Hormone Replacement ___

Cancer

Type: ________________

__Radiation/Chemotherapy

Cardiovascular

__ Angina/Heart Disease

__Artificial Heart Valve

__Mitral Valve Prolapse

__High Blood Pressure

__Low Blood Pressure

__Heart Prosthetic/ Bypass

__Heart Murmur

__ Heart Attack

__ Stroke

__ Heart Lesions/Congenital

__Endocarditis

__ Rheumatic Fever

Endocrinology

__ Jaundice

__ Kidney Disease

__ Liver Disease

__ Thyroid Disease

__ Diabetes I

__Diabetes II

__Hepatitis

Gastrointestinal

__Ulcers (Stomach)

__Gastrointestinal Disease

__GERD/Heartburn

__ Colitis

__Gall Bladder Issues

Respiratory

__Emphysema

Respiratory Cont.

__Respiratory Problems

__Sinus Problems

__Sleep Apnea

__Tuberculosis

__Shortness of Breath

__Lung Disease

__Asthma

Hematologic/Lymphatic

__Blood Disorders

__Excessive Bleeding

__Blood Transfusion

__Blood Clotting Problems

__Anemia

Viral Infections

__HIV

Viral Infections Cont.

__AIDS

__Fever Blisters/Herpes

__STD

Musculoskeletal

__Arthritis

__Rheumatoid Arthritis

__Joint Replacement

Type: ______________

__Bisphosphonate Use

Neurological

__Psychiatric Care

__Dizziness/Fainting

__Addiction

__Seizures

__Neurologic Disorder

Other (Please Specify)

HIPAA—Privacy Practices

"I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: 1. Treatment (including direct and indirect treatment by other health practitioners involved in my treatment); 2. Obtaining payment from third party payers (e.g. my insurance company); 3. The day-to-day healthcare operations of your practice.

I have also been informed and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my right under HIPAA. I understand you reserve the right to change the description of the uses and disclosures of my protected health information and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected."

Appointment Policy

It is my responsibility to keep the appointments that I schedule and arrive on time.
24-hour notice is required for cancellations. Patients that arrive more than 15 minutes late without notifying the office will be rescheduled to a later date.
3 cancellations or no-show/late appointments without proper notice may result in a missed appointment fee of $25.00 or termination from the practice.
I understand failure to keep multiple appointments may require future appointments to have a down payment that will not be refunded in the event I fail to keep the appointment. The fee can be up to 50% of my expected copayment.

Insurance/Payment Policy

Payment is due at the time of service unless other arrangements are made.
Insurance estimates are not a guarantee of payment. Estimates are due at the time of service. Patients are responsible for knowing and understanding their insurance. We are not responsible for keeping track of insurance benefits or maximums.
Patients are responsible for any services not paid by insurance. If insurance does not pay after 60 days, we may send a bill for the full balance.
A fee of 1.5% may be added to the balance for any late payments after the third billing cycle and will incur every month the account is delinquent.
A collection cost of 35% will be added to the balance if the account is sent to collections for non-payment.
If you are unable to provide proof of insurance you will be required to pay for services rendered at each visit.
If you choose to pay by credit card, a fee may be attached to your total payment.
Payment is accepted in the form of cash/check/money order. Major credit cards are accepted but may incur a 3% convenience fee. A $30.00 fee will be assessed to my account to cover the non-sufficient fund fee charged to Polish Crown Dental for failure of a check payment to clear the bank.
"I hereby assign insurance benefits to be paid directly to Polish Crown Dental LLC. I hereby agree to directly forward any insurance payments to Polish Crown Dental LLC that are mailed directly to me within 30 days. I hereby authorize the use of my signature on all insurance submissions."

Patient Disclosure

My signature below affirms that I understand and accept the HIPAA, Appointment, and Insurance/Payment Policies as listed on this form. I certify that I have read and understand the attached information and the information I have provided is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff responsible for any action they take or do not take because of errors or omission that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: ____ Date: ________________

If Legal Guardian, please print: ____