WELCOME!

Patient Information

Today's Date: _____/ _____/ _____

First Name: _____MI: _____ Last Name: _____

Date of Birth: _____ Sex: (Circle one) Female/Male Social Security #: _____

Address: _____

Primary Phone #:_____Cell/Home/Work Secondary Phone #:_____Cell/Home/Work

Email: _____

Occupation: _____ Employer/School: _____

Status: (Circle one) Minor/Single/Married/Widowed/Divorced/Separated/Partnered for _____ years

Emergency Contact: _____ Relationship: _____ Phone #: _____

Preferred Pharmacy: _____ Phone #:_____

Who may we thank for referring you? _____

Account Holder Information *If different than patient

First Name: _____MI: _____ Last Name: _____

Date of Birth: _____ Sex: (Circle one) Female/Male Social Security #: _____

Address: _____

Primary Phone #:_____Cell/Home/Work Secondary Phone #:_____Cell/Home/Work

Email: _____

Primary Dental (NOT MEDICAL) Insurance

Subscriber Name: _____Subscriber D.O.B._____

Subscriber's Relationship to Patient: (Circle one) Self/Spouse-Partner/Guardian/Other

Subscriber Address: _____

Insurance Company: _____ Phone #: _____

SSN/ID#: _____Group #: _____ Group Name/Employer: _____

Claims Mailing Address: _____

_____Electronic Payer ID: _____

Secondary Dental (NOT MEDICAL) Insurance

Subscriber Name: _____Subscriber D.O.B._____

Subscriber's Relationship to Patient: (Circle one) Self/Spouse-Partner/Guardian/Other

Subscriber Address: _____

Insurance Company: _____ Phone #: _____

SSN/ID#: _____Group #: _____ Group Name/Employer: _____

Claims Mailing Address: _____

_____Electronic Payer ID: _____

ASSIGNMENT AND RELEASE I, the undersigned, hereby authorize and direct my insurance carrier to pay directly to Dr. George J. Kassolis, DDS, PA all insurance benefits, if any, due to me under by insurance plan. I further agree to pay the balance of the charges not paid by my insurance. Any balance that is not paid within 45 days by my insurance will also be my responsibility. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I as a legal guardian give consent for treatment for this and future services rendered. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I understand and agree that **(1)** if I do not have dental insurance, full payment is due at the time of service; **(2)** if I do have dental insurance, I am responsible to pay an estimated copayment to Dr. Kassolis' office at the time of all services. Any overpayment will be placed as a credit on my account or refunded to me by a mailed check (per my request); **(3) all treatment will be billed using the above information. Therefore, I must complete this form in its entirety. Any errors or omission of information provided above will result in Dr. Kassolis' inability to properly file dental claims on my behalf thus resulting in denial of claims and/or full balance being transferred to patient responsibility; (4)** it is my responsibility and not the responsibility of Dr. George J. Kassolis's office to know if my treatment will be covered by my insurance or if I have any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the services I receive; **(5)** it is my responsibility to know if Dr. George J. Kassolis, DDS, PA is a contracted in-network provider recognized by my insurance company or plan. If Dr. George J. Kassolis, D.D.S., P.A. is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment; **(6)** that Dr. George J. Kassolis, DDS, PA may charge a $35.00 or $55.00 fee if I do not show up for my appointment or cancel without a 24 hour notice; and **(7)** that any account balance that is 90 days past due will be sent to collections and that it is my responsibility to ensure that my insurance and contact information is always current and updated with the office of Dr. George J. Kassolis, DDS, PA and that I will be responsible for any expenses incurred by Dr. George J. Kassolis, D.D.S, P.A. by the collection agency.

Responsible Person/Patient:

Name: _____Signature: _____Date: _____

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontic (braces) treatments?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

	Yes	No	DK
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Are you now under the care of a physician?	❑	❑	❑
Physician Name: _____			
Phone: *include area code* (____) _____			
Address/City/State/Zip: _____			
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
If yes, what condition was treated? _____			
Date of last physical exam: _____			
Do you wear contact lenses?	❑	❑	❑
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)?	❑	❑	❑
Are you taking or scheduled to begin taking either of the medications alendrontate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?	❑	❑	❑
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer?	❑	❑	❑
Date Treatment Began: _____			

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	❑	❑	❑
If yes, what was the illness or problem? _____			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	❑	❑	❑
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____			
Do you use controlled substances (drugs)?	❑	❑	❑
Do you use tobacco (smoking, snuff, chew, bidis)?	❑	❑	❑
If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	❑	❑	❑
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are you:			
Pregnant?	❑	❑	❑
Number of weeks: _____			
Taking birth control pills or hormone replacement?	❑	❑	❑
Nursing?	❑	❑	❑

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? ❑ ❑ ❑
Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to, or have you had a reaction to: **Yes No DK**
To all **yes** responses, specify type of reaction.

Local anesthetics _____	❑	❑	❑
Aspirin _____	❑	❑	❑
Penicillin or other antibiotics _____	❑	❑	❑
Barbituates, sedatives, or sleeping pills _____	❑	❑	❑
Sulfa drugs _____	❑	❑	❑
Codeine or other narcotics _____	❑	❑	❑
Metals _____	❑	❑	❑
Latex (rubber) _____	❑	❑	❑
Iodine _____	❑	❑	❑
Hay fever / seasonal _____	❑	❑	❑
Animals _____	❑	❑	❑
Food _____	❑	❑	❑
Other _____	❑	❑	❑

	Yes	No	DK
Heart murmur	❑	❑	❑
Mitral valve prolapse	❑	❑	❑
Artificial heart valves	❑	❑	❑
Rheumatic fever	❑	❑	❑
Cardiovascular disease	❑	❑	❑
Angina	❑	❑	❑
Arteriosclerosis	❑	❑	❑
Congestive heart failure	❑	❑	❑
Coronary artery disease	❑	❑	❑
Damaged heart valves	❑	❑	❑
Heart attack	❑	❑	❑
Low blood pressure	❑	❑	❑
High blood pressure	❑	❑	❑
Congenital heart defects	❑	❑	❑
Pacemaker	❑	❑	❑
Rheumatic heart disease	❑	❑	❑
Abnormal bleeding	❑	❑	❑

	Yes	No	DK
Anemia	❑	❑	❑
Blood transfusion	❑	❑	❑
If yes, date: _____			
Hemophilia	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Arthritis	❑	❑	❑
Autoimmune disease	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Sinus trouble	❑	❑	❑
Tuberculosis	❑	❑	❑
Cancer/Chemotherapy/ Radiation treatment	❑	❑	❑

	Yes	No	DK
Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Diabetes Type I or II	❑	❑	❑
Eating disorder	❑	❑	❑
Malnutrition	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux/Persistent heartburn	❑	❑	❑
Ulcers	❑	❑	❑
Thyroid problems	❑	❑	❑
Stroke	❑	❑	❑
Glaucoma	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑

	Yes	No	DK
Neurological disorders	❑	❑	❑
If yes, specify: _____			
Sleep disorder	❑	❑	❑
Mental health disorders	❑	❑	❑
If yes, specify: _____			
Recurrent infections	❑	❑	❑
Type of infection: _____			
Kidney problems	❑	❑	❑
Night sweats	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck	❑	❑	❑
Severe headaches/ Migraines	❑	❑	❑
Severe of rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Excessive urination	❑	❑	❑

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ ❑ ❑

Name of physician or dentist making recommendation: _____ Phone: (_____) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ❑ ❑ ❑

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will reyl on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. 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 omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

For Office use ONLY:

☐Medical Alerts/Precautions ☐Allergies ☐Premed ☐Blood Thinner ☐Osteoporosis Medication ☐Other

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by (print name) _____

Signature: _____ Date: _____

Witness: _____ Date: _____

George J. Kassolis, D.D.S., P.A.

16918 York Road, Suite 102
Monkton, Maryland 21111
(410) 329-6300

Patient Records Release Authorization Form

Please send a copy of dental records, radiographs, and any other pertinent information regarding this/these patients.

Can use 1 form for entire family- List all names and DOB's here

Name of Patient(s)/DOB: _____
_____
_____
_____

Name of New Dental Office: George J. Kassolis, D.D.S, P.A.
Address: 16918 York Road, Suite 102
Monkton, Maryland 21111
herefordfamilydental@gmail.com
Phone Number: (410) 329-6300
Fax Number: (443) 491-3314

Name of Old Dental Office: _____
Address: _____
_____
_____
_____
Phone Number: _____
Fax Number: _____

I authorize release of any information and dental records to your office, George J. Kassolis, D.D.S, P.A.

Authorized Signature: _____

Date: _____

Office use ONLY:
Date of request_____ Initials_____ Being sent via: Email/Mail

BWX_____ PAN_____ FMX_____ OTHER_____