KURT R. KWIATKOWSKI DDS, SC
ARTISTRY • INTEGRITY • PASSION

PATIENT INFORMATION

Date: ______ ☐NEW PATIENT ☐UPDATE

Patient: ______

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: ______ Patient SSN: ______

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

HOME:
CELL:
OTHER:
PAGER:
FAX:

E-Mail:

Referral? ☐Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel:

EMPLOYMENT INFORMATION

Employer: ______ Occupation: ______

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

WORK: X
DIRECT:
OTHER:
PAGER:
FAX:

E-Mail:

INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: ______ Subscriber SSN: ______

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ______ ID No.: ______

Address:

TEL:
TOLL-FREE:
FAX:

CITY ST ZIP CODE

SECONDARY INSURANCE CARRIER:

Group/Policy No.: ______ ID No.: ______

Address:

TEL:
TOLL-FREE:
FAX:

CITY ST ZIP CODE

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PREVIOUS DENTIST INFORMATION

Dentist: ______________________ Telephone: ______________________

Clinic/Facility: ______________________

Address: ______________________

____
CITY ST ZIP CODE

Reason for changing: ______________________

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: ______________ Treatment Type: ______________

Would you like to have a VisiLite oral cancer screening? ☐Y☐N

**Note: Some insurance plans do not cover this service; please check your plan documents for details.*

☐Y☐N Are you currently having dental discomfort? If yes, explain: ______________
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: ______________
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: ______________
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Have missing teeth been replaced?
☐Y☐N Orthodontic appliances now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you want to become a regular continuing care patient in our practice?
☐Y☐N Do you want your mouth properly restored and pain free?
☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

____

The most important concerns regarding my dental treatment are:

____

What factors are most important for your satisfaction with our office?

____

Any additional concerns/comments?

____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

____

☐Y☐N Any unusual speech habits? If yes, explain: ______________
☐Y☐N Any lost teeth? If yes, list: ______________
☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

____

PRIMARY PHYSICIAN INFORMATION

Physician: ______________________ Telephone: ______________________

Clinic/Facility: ______________________

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MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? ____________
☐Y☐N Any serious illnesses/surgeries? ____________
☐Y☐N Use tobacco in any form? If Yes, Type: ____________
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: ____________

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

____

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BULIMIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐CHICKEN POX
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐FREQUENT EAR INFECTIONS
☐ FREQUENT HEADACHES
☐HEARING PROBLEMS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐PACEMAKER
☐OTHER – PLEASE LIST: ____________
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐OTHER – PLEASE LIST: ____________
☐CODEINE
☐DAIRY
☐LATEX
☐LACTOSE INTOLERANCE
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐SLEEPING PILLS
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐OTHER (PLEASE LIST BELOW)
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

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Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **We are only in network for Delta Dental Premier, United Health Care, and Assurant.** ____________ initial
- **It is the patient's responsibility to know and understand their insurance coverage.** Many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level. Please understand, that we do our best to keep our patients updated with their insurance coverage but **NO ESTIMATE IS A GUARANTEE OF PAYMENT**. Patients are responsible for all charges not paid by your insurance. ____________ Initial
- **Workers Compensation claims** will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. The patient is responsible for paying the treatment total on the day of service. Any insurance payments received would then be reimbursed back to the patient.
- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless **prior** financial arrangements have been made.
- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover)
  - 10% Discount for our uninsured cash/check/debit paying patients
  - Various financing options with CareCredit® and CitiHealth®
- **Balances left over 90 days** may be turned over to our collection agency if alternative payment arrangements have not been made. ____________ Initial

Short Cancelled/ Missed Appointments

- Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you. **Please give 48 hours notice** if you are unable to keep your reserved time. Any combination of two missed or short cancelled appointments in a 12 month period may result in dismissal from our practice. __________ Initial

By signing below I acknowledge I have read and understand the guidelines above.

Signature____ **Date:**______________________

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

____________________________________ ____________________
Signature **Date**

____
Printed Name

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

____

____

____

☐ I give permission for the following communications to be used by Dr. Kurt Kwiatkowski DDS, SC:

☐ Cell phone: ☐ Text Message reminders permitted

☐ Home phone ☐ Work ☐ E-Mail

☐ I am granting permission for Dr. Kurt Kwiatkowski DDS, SC to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for Dr. Kurt Kwiatkowski DDS, SC to leave a message with any person who may answer my phone or on my voicemail of the following numbers:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back

☐ Other: ____________________________________

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

____

____

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other – please list:

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PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Dr. Kwiatkowski of the dental benefits otherwise payable to me.

I hereby authorize Dr. Kwiatkowski to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature:____ Date:____________________

Print Name: ____