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SummitFamilyDentalCare.com

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Personal Information

Patient Name ____________________

How do you wish to be addressed? ____________________

Patient Number (to be given by the office): ____________________

Address: ____________________

City: ____________ State: ___ Zip: ________

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Minor

If Minor, Parent's or Guardian's Name:

____

Date of Birth: ____________________

Phone: Residence: ____________ Work: ____________

Cell: ____________ email: ____________

Do we have permission to:

Leave a message on your home answering machine? ☐ Yes ☐ No

Call or leave a message at your place of employment? ☐ Yes ☐ No

Leave a message on cell phone or text message? ☐ Yes ☐ No

Discuss your Medical Condition with your family? ☐ Yes ☐ No

If yes, with whom? ____________________

____

Purpose of Visit: ____________________

Patient/Parent Social Sec. #: ____________________

Preferred Payment Method: ☐ Cash ☐ Check ☐ Credit Card

Other family who are patients here: ____________________

Someone not living with you to notify in case of emergency:

Name: ____________________

Relationship: ____________ Phone: ____________

Employer Information

Employer Name ____________________

Position: ____________________

How long have you been at current employer? ____________

Employer Address: ____________________

City: ____________ State: ___ Zip: ________

Who is responsible for this account? ____________

Referral Information

Who may we thank for this referral? ____________

Address: ____________________

City: ____________ State: ___ Zip: ________

Dental Insurance Information

PRIMARY INSURANCE

Insurance Company: ____________________

Claims Address: ____________________

City: ____________ State: ___ Zip: ________

Insurance Company Phone Number: ____________

Group Number: ____________________

Name of Insured: ____________________

Relationship to Patient: ____________________

Social Security Number of Insured: ____________

Birth Date of Insured: ____________________

Name of Insured's Employer: ____________

SECONDARY INSURANCE

Insurance Company: ____________________

Claims Address: ____________________

City: ____________ State: ___ Zip: ________

Insurance Company Phone Number: ____________

Group Number: ____________________

Name of Insured: ____________________

Relationship to Patient: ____________________

Social Security Number of Insured: ____________

Birth Date of Insured: ____________________

Name of Insured's Employer: ____________

Authorize & Release

I authorize Summit Family Dental Care (also known as Gburek, Barone & Kupka, DDS, PC) to perform diagnostic procedures and treatment as may be necessary for proper care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I authorize payment of insurance benefits directly to Summit Family Dental Care, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for service. I understand that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or in part by my dental care payer. I attest to the accuracy of the information on this and all pages.

Patient's or
Guardian's Signature ____________________

Date: ____________________

Medical History

1. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

2. Have you taken any medication or drugs regularly during the past two years? ☐ Yes ☐ No
   If yes, please list: ______________________

3. Are you taking any medication, drugs or pills now? ☐ Yes ☐ No
   If yes, please list: ______________________

4. Are you aware of having an allergic (or adverse reaction) to any medication/substance? ☐ Yes ☐ No
   If yes, please list: ______________________

5. Have you been a patient in the hospital or had surgery of any kind in the past five years? ☐ Yes ☐ No
   If yes, please list: ______________________
   ____
   ____

6. Do you use more than two pillows to sleep? ☐ Yes ☐ No

7. Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

8. Indicate which of the following conditions you have had in the past, or have at present.
   Check all that apply.

☐ Heart (surgery/disease/attack)	☐ Asthma
☐ Chest pain	☐ Hay fever
☐ Congenital heart disease	☐ Latex sensitivity
☐ Heart murmur	☐ Allergies or hives
☐ High Blood Pressure	☐ Sinus trouble
☐ Mitral valve prolapse	☐ Radiation therapy
☐ Artificial heart valve	☐ Chemotherapy
☐ Heart pacemaker	☐ Tumors
☐ Rheumatic Fever	☐ Hepatitis A
☐ Arthritis/Rheumatism	☐ Hepatitis B or C
☐ Cortisone medication	☐ AIDs/ HIV Positive
☐ Swollen Ankles	☐ Cold sores/ Fever blisters
☐ Stroke	☐ Blood transfusions
☐ Diet (special/restricted)	☐ Hemophilia
☐ Artificial joints (hip/knee/etc)	☐ Sickle cell disease
☐ Kidney trouble	☐ Bruise easily
☐ Ulcers	☐ Liver disease
☐ Diabetes	☐ Yellow jaundice
☐ Thyroid Problems	☐ Neurological disorders
☐ Glaucoma	☐ Epilepsy or seizures
☐ Contact lenses	☐ Fainting or dizzy spells
☐ Emphysema	☐ Nervous/Anxious
☐ Chronic cough	☐ Psychiatric/Psychological Care
☐ Tuberculosis	

9. Do you have or have you had any disease, condition or problem not listed? ☐ Yes ☐ No
   If yes, please explain: ______________________
   ____
   ____

10. **Women:**
    Are you pregnant? ☐ Yes ☐ No
    If yes, how many months? __________
    Are you nursing? ☐ Yes ☐ No
    Do you take birth control pills? ☐ Yes ☐ No

Patients Name ______________________

Name of Medical Doctor: ______________________

Address: ______________________

Phone Number: ______________________

Date of last visit: ______________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: ______________________

Date: ______________________

If you have answered yes to any previous questions can you please give us more details: ______________________
____
____
____
____
____

OFFICE USE ONLY

History review: ______________________
____
____
____
____
____
____

Dentist signature: ______________________

Date: ______________________

Dental History

Patients Name ____________________

Reason for visit today: ____________________

____

Date of: Last dental cleaning: ____________________

Last dental visit: ____________________

Last full mouth X-rays: ____________________

What was done at your last dental visit? ____________________

____

____

Previous Dentist's Name: ____________________

Address: ____________________

City: ____________________ State: ____ Zip: ________

Phone: ____________________

How often do you have dental examinations? ____________________

How often do you brush your teeth? ____________________

How often do you floss? ____________________

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: ____________________

____

____

____

Are any of your teeth sensitive to:

Hot or cold? ☐ Yes ☐ No

Sweets? ☐ Yes ☐ No

Biting or chewing? ☐ Yes ☐ No

Do you notice any mouth odor or bad taste? ☐ Yes ☐ No

Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No

Does food tend to become caught in your teeth? ☐ Yes ☐ No

If yes, where ____________________

Do you:

Clench or grind your teeth while awake? ☐ Yes ☐ No

Clench or grind your teeth while you sleep? ☐ Yes ☐ No

Bite your lips or cheeks regularly? ☐ Yes ☐ No

Hold foreign objects with your teeth? ☐ Yes ☐ No

(pencils, pipe, pins, nails, fingernails)

Mouth breathe while awake or asleep? ☐ Yes ☐ No

Have tired jaws, especially in the morning? ☐ Yes ☐ No

Smoke or use chewing tobacco? ☐ Yes ☐ No

If yes, how often do you chew? ____________________

How many cigarettes a day? ____________________

Drink alcoholic beverages? ____________________ ☐ Yes ☐ No

How many per day per week? ____________________

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No

Oral surgery? ☐ Yes ☐ No

Periodontal treatment? ☐ Yes ☐ No

Your teeth ground or the bite adjusted? ☐ Yes ☐ No

A bite plate or mouth guard? ☐ Yes ☐ No

A serious injury to the mouth? ☐ Yes ☐ No

If yes, describe ____________________

____

____

Have you ever experienced:

Clicking or popping of the jaw? ☐ Yes ☐ No

Joint, ear or side of face pain? ☐ Yes ☐ No

Difficulty in closing mouth? ☐ Yes ☐ No

Headaches, neck aches or shoulder aches? ☐ Yes ☐ No

Sore muscles? (neck or shoulders) ☐ Yes ☐ No

Are you satisfied with your teeth's appearance? ☐ Yes ☐ No

Would you like to keep all of your teeth, all of your life? ☐ Yes ☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

If so, what is your biggest concern? ____________________

____

____

____

____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No

If so, please describe: ____________________

____

____

____

____

Is there anything else about having dental treatment that you would like us to know? ____________________

____

____

____

____

Financing Options

Summit Family Dental Care is committed to providing quality dental care to the entire family through exceptional service and the utilization of advanced technology. Please do not hesitate if you have questions regarding these polices.

Methods of Payment

- Cash or check (Treatment plans of $500 or greater where there is no insurance coverage, will be discounted 5% if fully paid in cash or check on or prior to the day of treatment.)
- Credit card (Visa, MasterCard, American Express or Discover)
- Dental Fee Plan (application available)
- Dental insurance (described below)

Dental Insurance

- We are pleased that you have the benefit of dental insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company. **We will need you to contact your insurance company to find out your benefits, deductibles and co-payments. If you would like our assistance interpreting this information, please bring in a copy of your benefit booklet and we will be happy to help.**
- As a courtesy to you, we will file your insurance and accept assignment of benefits if you have signed the insurance payment authorization form. **We ask that your estimated co-payment and deductible be paid at the time of service.**
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover.
- We also will submit your secondary insurance claims. We need you to supply us with all necessary forms in a timely fashion. Most insurance companies require filing within a certain number of days of payment by your primary insurance company.

Related Information

- Returned checks are subject to a $30.00 fee. Balances older than 90 days may be subject to additional collection fees and interest charges. These additional fees will be applied to the unpaid balance at the end of the month.
- In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs and collection agency fees).
- Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. 48-hours notice is needed to avoid a $50.00 charge.

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

Print Name: ____________________

Signature: ____________________

Date: ____________________

Acknowledgement of Receipt of NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, ____________________ (print name), have received a copy of this office's Notice of Privacy Practices.

Print Name: ____________________

Signature: ____________________

Date: ____________________

OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ Other, please specify ____________________

____

____

Release of Information

I, ____________________(print name), ____________ (date of birth) give permission to Summit Family Dental Care (also known as Gburek, Barone & Kupka, DDS, PC) to release my:

- ☐ **dental information**
- ☐ **financial information**
- ☐ **medical information**

from this office to:

Print Name: ____________________

Date of Birth____________________

Print Name: ____________________

Date of Birth____________________

Print Name: ____________________

Date of Birth____________________

Information will NOT be released to any person, regardless of relationship, without the patient's signed consent. This consent for release of information is valid until otherwise revoked.

Patient Signature____________________

Date: ____________________

Information Release Form for Medical, Dental and Insurance Billing

Name: ____ **DOB:** ___/___/___

I, hereby request and authorize Summit Family Dental Care to disclose and provide copies of any and all clinical treatment and information concerning my care, which is in the possession of this person to any **Medical, Dental or Insurance Company**.

These records include, but are not limited to:

Personal patient information, medical, dental histories, Insurance information, examination records, radiographs, clinical photographs, treatment plans, treatment record, referral and consultation recommendations and reports, diagnostic models, and other related materials.

I expressly release from liability the above-named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

Information will NOT be released to any person, regardless of relationship, without the patient's signed consent. This consent for release of information is valid until otherwise revoked.

Signed: ____ **Date:** ___/___/___

(Patient or Guardian)

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