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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.

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

(Patient or Guardian)

Date: ___/___/___