PATIENT INFORMATION

Full Name_____

Name you like to be called_____

Address_____

City_____Zip Code_____

Home Phone_____ Cell Phone_____

E Mail_____Work Phone_____

Social Security #_____Birth Date_____Sex_____

Employer_____Marital Status_____

Whom may we thank for referring you/ referring dentist_____

Did you see us on Facebook____ Google_____ Yelp_____

In case of emergency contact_____

Their phone _____Relation to you_____

Name of Dental Insurance_____

(if two insurances, name both with primary first)

Phone of Primary Insurance_____Secondary_____

Employer who provides insurance_____

Person who is the insured_____ Their birthdate_____

Their SS#_____ Relationship to you_____

If you are on Medicare, your Medicare insurance is provided by _____

Today's date_____

PATIENT MEDICAL HISTORY

Patient Name_____ Date of last medical exam ____

Your medical physician_____Their phone_____

Are you currently being treated by a physician? yes___ no____

If yes, for what_____

Check if you currently or have ever had any of the following and list medications you are taking for that issue on the line following:

Medications

__ 1. Heart Murmur_____
__ 2. Rheumatic Fever_____
__ 3. Scarlet Fever _____
__ 4. Mitral Valve Prolapse_____
__ 5. Chest Pain (Angina) _____
__ 6. Pace Maker _____
__ 7. Heart Attack_____
__ 8. Stroke _____
__ 9. Circulatory Problems/ Blood Clot_____
__ 10. High Blood Pressure_____
__ 11. Low Blood Pressure_____
__ 12 .Cholesterol_____
__ 13. Fainting_____
__ 14. Seizures _____
__ 15. Convulsions_____
__ 16. Bronchitis_____
__ 17. Asthma _____
__ 18. Acid Reflux_____
__ 19. Ulcers_____
__ 20. Diabetes _____
__ 21. Gall Bladder Disease_____
__ 22. Prolonged Bleeding_____
__ 21. Hemophilia _____
__ 22. Anemia_____
__ 23. Kidney Disease_____
__ 24. Sickle Cell Disease_____
__ 25. Liver Disease _____
__ 26. Hepatitis A _____
__ 27. Hepatitis B_____
__ 28. Hepatitis C_____
__ 29. AIDS/HIV Positive_____
__ 30. Venereal Disease _____

Medications continued

__ 31. Herpes_____
__ 32. Osteoporosis _____
__ 33. Osteopenia _____
__ 34. Arthritis_____
__ 35. Joint Replacement _____
__ 36. Frequent Headaches _____
__ 37. Sleep Apnea_____
__ 38. Metallic Implants _____
__ 39. Eating Disorders _____
__ 40. Depression _____
__ 41. Alcoholism_____
__ 42. Drug Abuse _____Explain status_____
__43. Cosmetic Surgery_____
___44.Cancer_____
__ Other_____

What vitamins and/or supplements do you take?

_____
_____

Check if you are allergic to or ever had an adverse reaction to any of the following

_____penicillin	_____aspirin	_____cortisone
_____amoxicillin	____ acetaminophen (Tylenol)	_____local anesthetic
_____erythromycin	_____ ibuprofen (Advil,Motrin)	_____nitrous oxide
_____tetracycline	_____ naproxen (Aleve)	(laughing gas)
_____clindamycine	_____ codeine	_____metals
_____metronidazole(flagyl)	_____ percocet/percodan	_____costume jewelry
_____bactrim	_____ darvocet/darvon	___ iodine (shell fish, walnuts)
_____sulfa	_____ hydrocodone (Vicodin)	_____ latex

Other allergies

_____
_____

Surgeries

_____
_____
_____

Are you currently taking

Recreational Drugs yes___ no____ Tobacco in any form yes___ no___

Have you had your tongue or mouth pierced? yes_____no_____

To be answered by women only

Are you pregnant _____yes ____no If pregnant what is the due date _____
Are you nursing at this time _____yes _____no
Are you on hormone replacement therapy _____yes _____no

Please circle yes or no to the following questions

yes no a. Are you nervous or apprehensive concerning your visit today?
Explain_____

yes no b. Has a medical doctor ever recommended pre medication with antibiotics prior to routine medical/dental treatment?

yes no c. Do any of your teeth hurt?
If yes describe_____

yes no d. Do you get mouth sores?

yes no e. Do you grind or clench your teeth?

yes no f. Does your jaw click or hurt?

yes no g. Do you have an appliance for grinding teeth?

yes no h. Do you have pain when chewing?

yes no i. Does food pack between your teeth?

yes no j. Do you have frequent bad breath?

yes no k. Do you have a bad taste in your mouth?

yes no l. Do you have dry mouth?
Medications you are taking_____

yes no m. Has a dentist ever ground your teeth to correct your bite?

yes no n. Do your gums bleed?

yes no o. Are you happy with your smile?

yes no p. Would you like your teeth whiter?

yes no q. Have you ever had orthodontic treatment?

yes no r. Do you wear dentures or partials?

yes no s. Have you had your wisdom teeth removed?

yes no t. Do you have dental implants? Where?_____

yes no u. Do you breathe through your mouth?

Yes No v, Do you snore?

yes no w. Have you been told you have gingivitis or gum disease?

yes no x. Have you ever been treated for periodontal disease?

yes no y. Have you ever had a periodontal cleaning?

yes no z. Have you had root planing and scaling? When _____

yes no Have you ever been seen by periodontist?
If so, what for what reason_____

When was your last cleaning (hygiene) visit ?_____

I have my teeth cleaned every _____months.

When did you last have dental x-rays ? _____

What brings you to the dental office today?

_____

_____

_____

Have you ever had a bad experience in a dental office? If so please describe_____
_____

Check the following that apply I use…..

____hand toothbrush ____floss ____gum stimulators
____Waterpik ____irrigator ____ proxabrush
____tooth picks ____fluoride gel
____end tuft brush ____mouth rinse_____

____electric toothbrush brand_____
____other_____

The information I have written on the **Patient Medical History** found on this page and on the three proceeding pages is true and complete to the best of my knowledge. I **will** advise the dentist of any changes in my medical history should they occur. I consent to all dental procedures, medications and anesthetics deemed necessary to the diagnosis and treatment by Michael Kaye D.D.S and his associates for myself (or the patient named in medical history if you are the guardian). **I understand that I am encouraged to ask questions** regarding the diagnosis, treatment options, fees, sterilization and the detail involving all procedures before they are started. I further understand that it may be necessary to change the recommended treatment during the procedure due to unforeseen circumstances. In the event this occurs I understand that I will be informed either verbally or in writing of the changes and be given an opportunity to consent to such necessary changes.

Signature of patient or guardian_____date_____

For future use
I certify that there are no changes to my medical/dental history

Signature of patient or guardian_____date_____

Signature of patient or guardian_____date_____

Signature of patient or guardian_____date_____

Signature of patient or guardian_____date_____

Signature of patient or guardian_____date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practice*s containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a copy of the *Notice of Privacy Practice.*

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

Patient
Name_____date_____

Signature _____

Relationship to patient if guardian _____

RELEASE AND FINANCIAL RESPONSIBILITY

I understand that I am ***personally responsible*** for ***complete payment*** of all services , treatment and products at the time service is rendered unless financial arrangements have been made in advance and have been presented to me in writing. I understand, where applicable, credit reports may be obtained to facilitate payment arrangements if desired.

I hereby authorize payment from my insurance company be paid directly to Dr. Kaye for dental services rendered. I understand I am financially responsible for any charges not covered by my dental insurance. I further understand that any co-payments or money paid toward the treatment is an ***estimate only and actual amount owed will be determined at the time insurance payments are made.***

In the event of default I agree to pay interest, legal fees and collection costs and any attorney fees incurred as a result of non payment. I understand that if the entire balance of my account is not paid within 30 days of notification, finance charges will be assessed and my account will be in default. I understand that it is my responsibility to immediately update my records at this office in the event of any changes in address, phone number and insurance coverage. I will be held responsible for any repercussions as a result of my failure to report such changes.

I understand there is a standard fee of $25 per half hour for any appointments canceled within 48 hours of any scheduled appointment. In the event of emergency the 48 hour cancellation fee may be waived at the discretion of the office staff.

I hereby authorize Dr. Michael Kaye to release any information acquired in the course of my examination or treatment to my insurance carrier and/or other dental and medical professionals. Upon signing this document I am saying that I have read the above paragraph in its entirety.

_____Date_____

Signature of Patient (Parent or Guardian if a minor)

_____

Staff Signature as witness

Photography Release Agreement

For valuable consideration received, I hereby give Michael Kaye, D.S.S. the absolute and irrevocable right and permission, in perpetuity, with respect to the photographs that he has taken of me or in which I may be included with others.

a) To copyright the same in his own name or any other name that he may chose;
b) To use, reuse, and publish the same or in part, individually or in conjunction with other photographs, in any other medium and for any purpose whatsoever, including, but not limited to, illustration, promotion and advertising and trade; and
c) To use my name in connection therewith, if he so chooses.

I hereby release and discharge Michael Kaye D.D.S. from any and all present and/or future claims, causes of action, and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

This authorization and release shall also insure to the benefit of the legal representatives, licensees and assigns of Michael Kaye D.D.S., as well as, the person(s) for whom he took the photographs.

I am over the age of twenty-one. I have read the foregoing and fully understand and agree with the contents hereof.

Signed _____
Date_____