Georgia Knotek D.D.S. Personalized Dental Care

Name: _____ Social Security #: _____

Date of birth: _____ Age: _____ Sex: M / F Phone: _____Home/Cell

Address: _____City: _____ State: _____ Zip Code: _____

Email: _____Occupation: _____

Employer: _____Business Phone: _____

Physician: _____ Physicians Phone #: _____

Emergency Contact: _____Phone #: _____

Whom may we thank for referring you to our office? _____

Medical History: Please circle any of the following you had or have at present:

HEART CONDITION
HEART ATTACK OR STROKE
HEART MURMUR
CHEST PAINS (ANGINA)
HEART SURGERY
ARTIFICIAL HEART VALVE
HEART PACEMAKER
HIGH BLOOD PRESSURE
RHEUMATIC FEVER
ANEMIA OF HEMOPHILIA
BRUISE EASILY
SHORTNESS OF BREATH
SWELLING OF ANKLES
ARTIFICIAL JOINT (Knee, Hip, Etc.)
LUNG DISEASE
EMPHYSEMA
TUBERCULOSIS (T.B.)
ASTHMA OR HAY FEVER
SKIN RASHES OR HIVES
KIDNEY TROUBLE
DIABETES
SICKLE CELL DISEASE
SLEEP APNEA
ADHD
ACID REFLUX

LIVER DISEASE
HEPATITIS A (INFECTIOUS)
HEPATITIS B (SERUM)
YELLOW JAUNDICE
BLOOD TRANSFUSION
THYROID DISEASE
CORTISONE MEDICINE
GLAUCOMA
ARTHRITIS OR RHEUMATISM
PAIN IN JAW JOINTS
FAINTING OR DIZZY SPELLS
ALCOHOLISM
DRUG ADDICTION
CANCER OR TUMOR
RADIATION THERAPY
CHEMOTHERAPY (CANCER/LEUKEMIA)
HIV POSITIVE / AIDS
VENEREAL DISEASE
GENITAL HERPES
COLD SORES
EPILEPSY OR SEIZURES
PSYCHIATRIC TREATMENT
ANXIETY
AUTO IMMUNE

Do you have any other diseases, conditions or problems that are not listed above: YES / NO
If yes, please explain: _____

Are you allergic to any medicine, drug or other substance? YES / NO

If yes, please explain: _____

Are you presently taking any medications or drugs? YES / NO
If yes, please list:
_____

_____

Are you now or have you been under the care of a medical doctor (other than routine care) during the last two years?

YES / NO If yes, please explain:_____

When was your last physical exam by a Physician? _____

Have you ever been hospitalized or had surgery? YES / NO

Have you ever had a reaction to a local anesthetic? YES / NO

Any reactions or allergic symptoms to Novocain anesthetic? YES / NO

Have you ever had prolonged or unusual bleeding? YES / NO

Have you ever had complications or illness following dental treatment? YES / NO

Do you have any unhealed injuries or inflamed areas in or around your mouth? YES / NO

Have you ever experienced any growth or sore spots in your mouth? YES / NO

Does any part of your mouth hurt when clenched? YES / NO

Any difficult extractions in the past? YES / NO

Any prolonged bleeding following extractions in the past? YES / NO

Do your gums bleed? YES / NO

Have you ever had instructions on the care of your gums? YES / NO

Have you ever had instruction on the correct method of brushing your teeth? YES / NO

Do you chew on only one side of your mouth? YES / NO If yes, please explain: _____

Do you at the present time have any dental complaints? YES / NO If yes, what? _____

Do you habitually clench your teeth during the day or night? YES / NO

When was your last full mouth x-ray taken? _____Where? _____

Are there any parts of your mouth that is sore to pressure or irritants such as cold, sweets, etc…..? YES / NO

If yes, where? _____

Do you smoke or use smokeless tobacco? YES / NO

Are you nervous or concerned about having dental work done? YES / NO

WOMEN:
Are you pregnant now? YES / NO If yes, due date? _____

Are you practicing birth control? YES / NO

Do you anticipate becoming pregnant? YES / NO

Have you had any complications or problems with a previous pregnancy? YES / NO

DENTAL TREATMENT DESIRED (CIRCLE)

Check Up	Teeth Cleaning	Cavities Restored
Missing Teeth Replaced	Cosmetic Bonding	Teeth Extracted
Complete Dentures	Orthodontics	Teeth Bleaching

Other: _____

To the best of my knowledge the preceding answers are true and correct. If I have any changes in my health or medications, I shall inform Dr. Knotek at the next appointment without fail.

_____ _____
Signature Date

FINANCIAL RESPONSIBILITY AGREEMENT

Name of person financially responsible for this account? _____

Relationship to patient: _____Phone: (_____)_____Cell: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

Name of Employer: _____ Work Phone: (_____)_____

Name of closest relative not living with you: _____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Name of insured: _____Relationship to the patient: _____

Date of birth: _____ Social Security # _____

Name of Employer: _____ Work Phone: (_____)_____

____ I authorize use of this form on all my insurance submissions.
____ I authorize release of information to all my insurance carriers.
____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
____ I authorize payment directly to my doctor.
____ I permit a copy of this authorization to be used in place of the original.
____ I understand that I am financially responsible for any remaining balances not covered by insurance.
____ I understand that Dr. Knotek is not responsible for any verbal information given by insurance companies: although, she and her representatives strive for accurate information.

Signature: _____ Date: _____

NO DENTAL INSURANCE

I elect to pay cash_____, Check _____, Credit Card _____ on all visits as treatment progresses.
The undersigned agrees that all past due amounts beyond 30 days are subject to collections and/or small claims court. The undersigned accepts full responsibility and agrees to notify this office within 10 days of any change of address or phone number. The undersigned assumes and agrees to pay for all collection agency fees paid or incurred by us, collection agency fees can be up to an additional 50% of the amount turned over for collection. In the course of collection of the amount due, an attorney may be engaged by this office or by the collection agency to help with the collection. The undersigned agrees to pay reasonable attorney fees, court costs and other costs paid or incurred by this office or our collection agency while collecting the amount due.

Signature: _____ Date: _____

Relationship to patient: _____

GEORGIA KNOTEK, D.D.S. PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

Signature: _____ Date: _____

Please contact me on:
Cell _____
Home _____
Email _____

Is it ok to leave a detailed voicemail or email? Yes/No

Is there anyone that we may release information to about you? _____

Is there anyone we can NOT release information to? _____

For Office Use Only

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

_____ Individual refused to sign.

_____ Communications barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgement.

_____ Other (Please Specify Below)

_____

_____

_____