Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Date _____

Soc. Sec. # _____

Patient Information (Confidential)

Mobile # _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School / College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

☐ Check box if you would like info emailed. Email Address _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Driver's License # _____ Birthdate _____ Social Security # _____

Employer _____ Work Phone _____

IS this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security _____ Date Employed _____

Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Employer _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security _____ Date Employed _____

Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Employer _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max Annual Benefit _____

Patient Medical & Dental History

	Yes	No
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
Are you taking any medication(s) including non-prescription medicine?	☐	☐

If Yes, what medications are you taking? _____

_____

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Cardiovascular Disease	☐	☐	Chest Pain	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Congenital Heart Disease	☐	☐	Lung Disease	☐	☐
Rheumatic Heart Disease	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Psychiatric Treatment	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Bleeding Disorder	☐	☐
Blood Transfusion	☐	☐	Sinus/Nasal Problems	☐	☐	Recurring Infections	☐	☐
Transplants	☐	☐	Palpitations	☐	☐	Pneumonia	☐	☐

	Yes	No
Have you ever sought professional care for drug abuse, alcoholism or emotional disorder?	☐	☐
Do you have any other disease, condition or problem not listed here that you think the doctor should know about?	☐	☐
Do you smoke or chew tobacco?	☐	☐
Do you have any disease, take any drugs or have you any transplant operation that may suppress your immune system?	☐	☐
Do you wish to talk with the doctor privately about anything?	☐	☐
Do you use alcohol, cocaine, marijuana or other "street" drugs?	☐	☐
Are you allergic to or have you had any reaction to medication of any sort?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have clicking or popping of jaw joint, pain near ears, difficulty in opening your mouth, grind or clench your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Do you have any head, neck, or jaw injuries?	☐	☐
Do you have frequent headaches?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extraction in the past?	☐	☐
Have you had any orthodontic work?	☐	☐
Have you ever had a prolonged bleeding following extractions?	☐	☐
Do you wear contact lenses?	☐	☐
Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

I certify that I have read and understand the above information to the best of my knowledge. The above question have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Patient's Signature_____ Date_____

Louisville Oral Surgery and Dental Implant

JOSEPH H. CIESLAK, D.D.S., PLLC
Diplomate, American Board of Oral and Maxillofacial Surgery

HIPPA

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____

Sign Name – Patient or Representative

Relationship to Patient (if other than patient):_____

Date: _____/_____/_____