KAREN KRAMARCZYK DDS
family dentistry
OF MARICOPA

Today's Date

How did you hear about us?

☐ Walk-In ☐ Insurance ☐ Advertisement ☐ Referral   If referral, who referred you?

Primary Patient Information

Primary Patient

Name | DOB | SSN

Street Address | City | State | Zip Code

Home Phone | Mobile Phone | E-mail Address

Appropriate Contact Methods (check all that apply):

☐ Home Phone ☐ Mobile Phone ☐ E-mail ☐ Mail Address

Employer | Occupation

Business Phone | Business E-mail Address

Person to Notify in Case of an Emergency | Primary Phone | Alternate Phone

Additional Patient Information

Only complete fields where they would be different from the primary patient above

Patient 2

Name | DOB | SSN

Street Address | City | State | Zip Code

Home Phone | Mobile Phone | E-mail Address

Patient 3

Name | DOB | SSN

Street Address | City | State | Zip Code

Home Phone | Mobile Phone | E-mail Address

Patient 4

Name | DOB | SSN

Street Address | City | State | Zip Code

Home Phone | Mobile Phone | E-mail Address

Patient 5

Name | DOB | SSN

Street Address | City | State | Zip Code

Home Phone | Mobile Phone | E-mail Address

Patient 6

Name | DOB | SSN

Street Address | City | State | Zip Code

Home Phone | Mobile Phone | E-mail Address

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Please review and complete this form. If you are not using insurance, you are still responsible for reviewing and completing the Acknowledgement of Office Policies section below.

Primary Insurance Information

Person Responsible for Account ____________________ Insurance Company ____________________

Relationship to Patient ____________________ DOB ____________ SSN ____________

Please provide your insurance card to office staff for information verification, thank you.

Additional Insurance Information

Is the patient covered by additional insurance? ☐ Yes ☐ No If yes, please complete the information below

Subscriber's Name ____________________ DOB ____________ ID/SSN ____________

Insurance Company ____________________ Insurance Phone ____________________

Group # ____________________

Patient Insurance Authorization

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____________________ Date ____________

Acknowledgement of Office Policies

As a courtesy to our patients, we will gladly submit all claims to your insurance companies on your behalf. We will do our very best to get the maximum benefits allowed by your insurance.

Our office policy is to collect the "approximate" patient portion as treatments are rendered. Please do understand that what is quoted by our office is on an "estimate." Since insurance companies only provide percentages of benefit coverage and not their fees on each procedure, the exact figure is not known until the insurance pays.

In order for us to file your claims as accurately as possible and on time, we need to be aware of any changes in the status of your insurance policies as soon as you become aware so that we may be able to follow up and update our records. Otherwise, errors may occur which can cause a delay in processing of your claims at your insurance companies, or even a denial of claims. We would like to stress that you are ultimately responsible for any updates and changes in your dental insurance coverage.

Please be advised that you and/or your family will be responsible for any balance owed after we have exhausted all avenues with your insurance company.

In the event that you have an outstanding balance that has gone 90 days past due, the account may be turned over to a collection agency. You understand that if your account is turned over for collections, you agree to pay a 50% collection fee on any outstanding balances due.

Our office has a 24 hour cancellation policy. If you need to cancel your appointment and you have given us less than 24 hour notice, you may be charged a $25 cancellation fee. Our office also has a returned check fee of $25 that will be charged for any checks returned.

The office's privacy practices are included with this form or available on our website at copadental.com/forms. By signing below you acknowledge that you have reviewed and agree with the privacy practices as written.

I verify that I have read the above policies and authorize their use as they apply to me and/or my family.

Signature ____________________ Date ____________

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Please complete this form in its entirety, checking yes to only those that apply and providing additional detail where prompted.

Patient Name: ____________________

General Health History

Question	Yes	No
Is your general health good?	☐ Yes	☐ No
Have you been hospitalized or had a serious illness in the last three (3) years?	☐ Yes	☐ No

If yes, why? ____________________

Question	Yes	No
Are you being treated by a physician now?	☐ Yes	☐ No

Date of Last Medical Exam: ____________________ Date of Last Dental Exam: ____________________

Question	Yes	No
Have you had problems with prior dental treatment?	☐ Yes	☐ No
Are you in pain now?	☐ Yes	☐ No
Are you or could you be pregnant or nursing?	☐ Yes	☐ No

Have you Experienced?

Condition	Yes	No	Condition	Yes	No
Chest pain (Angina)	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Recent weight loss, fever, night sweats	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Persistent cough, coughing up blood	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Bleeding problems, bruising easily	☐ Yes	☐ No	Dry mouth	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No	Joint pain	☐ Yes	☐ No

Do you Have or Have you Had?

Condition	Yes	No	Condition	Yes	No
Heart disease	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Heart attack, heart defects	☐ Yes	☐ No	VD (syphilis or gonorrhea)	☐ Yes	☐ No
Heart murmurs	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Kidney, bladder disease	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Thyroid, adrenal disease	☐ Yes	☐ No
Asthma, TB, emphysema, other lung diseases	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Hepatitis, other liver disease	☐ Yes	☐ No	Psychiatric care	☐ Yes	☐ No
Stomach problems, ulcers	☐ Yes	☐ No	Radiation treatments	☐ Yes	☐ No
Allergies to drugs, foods, medications, latex	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
AIDS	☐ Yes	☐ No	Artificial joint	☐ Yes	☐ No
Tumors, cancer	☐ Yes	☐ No	Hospitalization	☐ Yes	☐ No
Arthritis, rheumatism	☐ Yes	☐ No	Blood transfusions	☐ Yes	☐ No
Eye diseases	☐ Yes	☐ No	Surgeries	☐ Yes	☐ No
Skin diseases	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No

Are you Taking?

Item	Yes	No	Item	Yes	No
Recreational drugs	☐ Yes	☐ No	Tobacco (in any form)	☐ Yes	☐ No
Drugs, medications, over-the-counter			Alcohol	☐ Yes	☐ No
medicines (ex. Aspirin), natural remedies	☐ Yes	☐ No	Birth control pills	☐ Yes	☐ No

Please list all ____________________

Additional Information and Acknowledgement

Question	Yes	No
Do you have or have you had any other diseases or medical problems NOT listed on this form?	☐ Yes	☐ No

If so, explain ____________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

____________________ Signature

____________________ Date