



Welcome TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # \_\_\_\_\_
SS # \_\_\_\_\_
Date \_\_\_\_\_

PATIENT INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Sex [ ] M [ ] F [ ] Married [ ] Widowed [ ] Single [ ] Minor
[ ] Separated [ ] Divorced [ ] Partnered for \_\_\_\_\_ years
E-mail \_\_\_\_\_ Alt. Phone #1 (\_\_\_\_) \_\_\_\_\_ Alt. Phone #2 (\_\_\_\_) \_\_\_\_\_
Employer/School \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_
Employer/School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_
Whom may we thank for referring you? \_\_\_\_\_
Person to contact in case of emergency \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

RESPONSIBLE PARTY

Name of Person Responsible for this Account \_\_\_\_\_ Relation to Patient \_\_\_\_\_
Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_
Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Bank \_\_\_\_\_
Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_
Currently a patient in our office? [ ] Yes [ ] No E-mail \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_
Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

ADDITIONAL INSURANCE

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_
Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

# DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_  
Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_  
Address \_\_\_\_\_

Check (✓) if you have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                        | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                     | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw           | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

# MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.  Yes  No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | Yes                      | No                       | Yes                      | No                       | Yes                      | No                       | Yes                      | No                       |
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Douglas J Kardynal, D.D.S.

We Cater To Cowards

4098 17 Mile Road  
Sterling Heights, MI 48310

Phone: (586) 978-0015

Fax: (586) 268-1660

Email: djkardynal@hotmail.com  
Website: douglaskardynaldds.com

## **Office Financial Policy**

**Thank you for choosing us as your Dental Health Care Provider. Our primary mission is to deliver the best comprehensive Dental Care possible.**

The following is a statement of our **Financial Policy**. Please understand that we value you as our patient and are committed to providing the best treatment as possible.

- Payment is due at time of service. This includes any deductibles, estimated copays, and any non-covered procedures by your insurance. We accept Cash, Check, Mastercard, Visa and Discover.
- Prepayment Courtesy is available (for those without insurance)
- By signing this form, you are authorizing our office to bill your dental insurance for the service provided on the date of service you are seen, and for your insurance company to make payment directly to our office.

**Minors must be accompanied by a parent or legal guardian for their first appointment.** We ask for a parent or legal guardian to be present at every appointment. If a parent or legal guardian are unable to be present after their first appointment, they must send the patient with a letter stating that we are aloud to treat patient without parent/guardian present. They also must be accompanied by an adult over the age of 18. **Payment will still owe at this time of service regardless if parent/guardian is present or not.**

### **Consent:**

I have read, understand and agree to the terms and conditions above.

**Patient's Name:** \_\_\_\_\_

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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Website: [douglaskardynaldds.com](http://douglaskardynaldds.com)

## **Notice of Privacy Practices Acknowledgement (HIPAA)**

**I hereby acknowledge that I received/ or was offered a copy of the Notice of Privacy Practices.**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Consent to Share Personal Health Information**

I give my permission for the following people to have unlimited access to my medical records, appointment information, and billing information at Douglas J. Kardynal, D.D.S. LLC. I understand that the following people will be able to make and cancel appointments for me and discuss billing questions and medical information with our staff. I also understand that at any time, I can remove any of these names from this list, and that they will no longer have access to my information.

Name	Relationship	Phone Number

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Website: [douglaskardynaldds.com](http://douglaskardynaldds.com)

## **Appointment Cancellation Policy**

If you must cancel an appointment, please call at least 24-hours in advance. 24-hour notice is defined as one business day. Messages left over the weekend are not consider sufficient notice. If you miss or cancel two appointments without 24-hour notice, you may be unable to schedule any further appointments in advance.

Failure to cancel without a 24-hour notice will result in a \$75 fee. You are responsible for this fee; it will not be billed to your insurance company. No further appointments will be scheduled until the cancellation fee has been reconciled.

**Patient's Name:** \_\_\_\_\_

**Patient/Guardian**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Douglas J. Kardyanl, D.D.S.**