THOMAS J. KEPIC, DDS, MSD
PERIODONTICS & DENTAL IMPLANTS

THOMAS J. KEPIC, D.D.S., M.S.D.
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SPECIALIST IN PERIODONTICS
WITH SERVICES IN IMPLANTS

PATIENT INFORMATION

Mr.
Mrs. ______________________________ Social Security #______________________________
Miss

Address ____ Home Phone____________________
Street City Zip

Age________ Date of Birth______________ Drivers license #__________________ Cell Phone ______________________

Employed by___________________________________Occupation____________________E-Mail _________________________

Business Address____ Business Phone_________________
Street City Zip

Do you have dental insurance through your job? ____________________ How long have you worked there?________

Insurance Company _______________________________ Union # ____________________ Policy #______________

Spouse's Name _____________________________ Date of Birth ________________ Spouse's SSN______________

Spouse's Employer ___________________________________Occupation___________________________________

Does your spouse have dental insurance that includes you? __________ How long has your spouse worked there?_________

Insurance Company______________________________ Union # ______________________ Policy #______________

Your family dentist ____ City_______________________________

How long have you been his/her patient? __________________________ Date of last visit________________________

Who referred you to this office?____

Emergency contact ____ Phone____________________

HEALTH HISTORY

Your general health constitutes an important factor, and in combination with other causes, may influence the course of periodontal disease. To assure your health during therapy and to assist in establishing a thorough diagnosis for successful treatment, please complete this confidential form.

Physician ___________________________________ City ________________________________ Phone___________________

Approximate date of last physical examination____

Please check the appropriate box in answer to the following questions.

Yes	No	?	
( )	( )	( )	Are you in good health? If no, what is the nature of your illness?__________________________________
( )	( )	( )	Are you now being treated by a physician? If so, for what?__________________________________
( )	( )	( )	Are you taking any drugs or medication? If so, what?__________________________________
( )	( )	( )	Have you ever been hospitalized? If so, when and for what?__________________________________
( )	( )	( )	Have you had excessive bleeding requiring special treatment? If so, details?__________________________________
( )	( )	( )	Do you have diabetes?
( )	( )	( )	Has anyone in your family ever had diabetes? If so, who?__________________________________

Yes	No	?	
( )	( )	( )	Have you experienced continuous excessive thirst or frequent night-time urination?
( )	( )	( )	Have you lost weight (with good appetite)?
( )	( )	( )	Do injuries or cuts heal very slowly?
( )	( )	( )	Does your mouth frequently seem dry?
( )	( )	( )	Do you consider yourself to be under mental or emotional stress?
( )	( )	( )	Do you smoke? If so, how much per day?________________
			How many servings of alcoholic beverages do you have in a week?________________
( )	( )	( )	(For females) are you pregnant? If so, how long? ________________

Place an X in the box if your answer is Yes.

Have you ever had any of the following?

( ) Heart Disease
( ) Swelling of ankles or feet
( ) Pain, pressure, or tightness in chest
( ) Heart Attack
( ) Rheumatic fever
( ) Low Blood Pressure
( ) High Blood Pressure
( ) Fainting or dizzy spells
( ) Frequent or severe headaches
( ) Kidney or liver disease
( ) Hay fever, sinus problems
( ) Osteoporosis
( ) Headaches when lying down
( ) Nervous breakdown, psychotherapy
( ) Lung disease (TB, asthma, emphysema)
( ) Hepatitis, liver disease, yellow jaundice
( ) Arthritis, sore joints
( ) Tumor or cancer
( ) Blood trouble, anemia, leukemia
( ) Venereal disease
( ) X-ray, cobalt, radium treatments
( ) Glaucoma
( ) Epilepsy
( ) Chest pain on mild exertion

Have you become sick from, shown an allergy to, or been told not to take:

( ) Antibiotics
( ) Codeine
( ) Novocaine, xylocaine, or other dental anesthetics
( ) Penicillin
( ) Aspirin
( ) Demerol
( ) Other (please specify) ________________________________

Are you now taking any of the following?

( ) Hormones (including birth control pills)?
( ) Dilantin
( ) Anticoagulants
( ) Tranquilizers
( ) Steroids or cortisone

Are you now taking or using medicines for:

( ) Diabetes (pills or shots)
( ) Sleeping
( ) Heart or blood pressure (digitalis, nitroglycerin, reserpine)
( ) Stomach trouble (ulcer or other)
( ) Nerves (tranquilizers)
( ) Headaches
( ) Blood (liver or iron pills)
( ) Arthritis or osteoporosis
( ) Allergy
( ) Thyroid
( ) Psychotherapy
( ) Infection

Are you now:

( ) On a prescribed diet
( ) Wearing contact lenses

Do you have any disease, condition, or problem not listed above that you think I should know about? If so, please explain below:

DENTAL HISTORY

Please check the appropriate box in answer to the following questions.

Yes	No	?	
( )	( )	( )	Do your gums or teeth hurt now?
( )	( )	( )	Do your gums bleed?
( )	( )	( )	Are you aware of a bad taste or odor in your mouth?
( )	( )	( )	Have you had gum boils or abscesses within the past three months?
( )	( )	( )	Have you had a toothache within the past three months?
( )	( )	( )	Are any of your teeth particularly sensitive to hot or cold?
( )	( )	( )	Do you have frequent blisters or canker sores on your lips or mouth?
( )	( )	( )	Have you ever had “trenchmouth” or “pyorrhea”?
( )	( )	( )	Have you ever had a burning sensation of the tongue?
( )	( )	( )	Does your jaw ever get “out of joint”, “click”, or cause pain?
( )	( )	( )	Do you clench or grind your teeth?
( )	( )	( )	Have you ever had periodontal (gum) treatment? If so, when?________________
( )	( )	( )	Have you ever been treated by a periodontist? If so, when?________________
( )	( )	( )	Have you ever had orthodontic treatment (braces)? If so, when?____________
( )	( )	( )	Are you unusually apprehensive about dental treatment?
( )	( )	( )	Do you clean between your teeth? If so, with what?____________________
( )	( )	( )	Have you ever been shown how to use dental floss?
( )	( )	( )	Have you had any teeth extracted within the past five years? If so, how many?_________
( )	( )	( )	Have you ever been tested for AIDS?______________________________

Please answer the following questions:

How often do you brush your teeth?____

What type of tooth brush do you use (hard, medium, soft)?____________________________

When were your teeth last “cleaned” by a dentist or dental hygienist?______________________

How frequently have your teeth been “cleaned” by a dentist or a dental hygienist in the last five years?__________

Patient Statement and Signature:

To the best of my knowledge, the above information I have noted is correct.

____

Patient’s Signature **Date**

FINANCIAL AGREEMENT

I understand I am **financially responsible to Dr. Kepic for all charges for services received** and that payment is due in full at the time such services are rendered. All accounts not paid within 30 days of treatment shall be subjected to a late payment fee of 1.5 % per month of the adjusted balance, or 18% annual percentage rate. Such late payment fee shall be waived for any account paid in full within 90 days of treatment. The underdesigned agrees, whether he/she signs as agent or as patient, that in consideration of the treatment to be rendered to the patient, he/she hereby individually obligates himself/herself to pay Dr. Kepic in accordance with regular rates and terms of this dental office. Should accounts be referred to an attorney or collection agency for collection, the underdesigned shall pay actual attorney's fees and collection expense.

ASSIGNMENT OF INSURANCE BENEFITS

Insurance is billed as a courtesy to the patient and is not an obligation. Any fees not covered by the insurance plan will be the responsibility of the patient. The underdesigned authorizes, whether he/she signs as an agent or as a patient, direct payment to Dr. Kepic of any insurance benefits otherwise payable to or on behalf of the underdesigned for treatment rendered. It is agreed that payment to Dr. Kepic, pursuant to this authorization, by any insurance company shall discharge said insurance company of any and all obligations under a policy to extent of such payment. **It is understood by the underdesigned that he/she is financially responsible for charges not covered by this assignment.**

Any condition precedent to recovery or administrative appeals required by the policy shall be the sole responsibility of the patient/guarantor, and not Dr. Kepic. This is requirement shall apply to any and all treatment rendered by Dr. Kepic and his staff.

Signature________________________________ Date _________________

CONSENT FOR DENTAL TREATMENT ADULT PATIENT

I (print name) ____ herewith grant my permission to Thomas J. Kepic DDS, MSD, and his dental staff to perform the following dental procedures: A complete periodontal examination, periodontal maintenance, administer local anesthetic, do diagnosis or treatment and order x-rays.

Signature________________________________ Date _________________

CONSENT FOR DENTAL TREATMENT OF A MINOR

I (print name) ____, the parent and/ or legal guardian of (print name) ____, a minor, whose address is: ____, and date of birth is: ______________________,

Herewith grant my permission to Thomas J. Kepic DDS, MSD and his dental maintenance, administer local anesthetic, do diagnosis or treatment and order x-rays.

Signature of Parent and/or Legal Guardian ________________________________

Date _________________

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Thomas J. Kepic, DDS, MSD
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My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers and my health care services
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental providers *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*.
I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain the current copy of the *Notice of Privacy Practices.*

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

Patient Name: ____ Date:_____________________

Signature :____

Relationship to Patient: ________________________________

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due the following reason:

- ○ The patient refused to sign
- ○ Communication barrier
- ○ Emergency situation
- ○ Other