WELCOME TO OUR PRACTICE

Patient Registration **Date**_____

Patient Name: _____
First MI Last Nickname

Mailing Address_____ Apt #____ City_____

State_____ Zip_____ Home #_____ Work #_____

Cell Phone_____ Date of Birth___/_____/_____ Age_____

Sex: M F Marital Status: M S D W Social Security#_____

Dentist_____ Orthodontist_____ Referred By_____

Emergency Contact Name_____ #_____

Patients Employer Name_____

Responsible Party Information: (for patients under the age of 18)

Name_____ Relationship to Patient_____
Address_____ Employer _____
Home Phone_____ Work Phone_____ Ext._____
DOB___/___/___ Social Security #_____ Sex: M F

INSURANCE INFORMATION:

Our office is IN NETWORK FOR CIGNA RADIUS, METLIFE, AMERITAS AND DELTA. WE ARE OUT OF NETWORK FOR ALL OTHER INSURANCE COMPANIES.

We will need a copy of your current insurance cards, to assist in filling your claim

Primary Dental Information

Policy Holder _____

Ins. Company_____

Address_____

Policy #_____ Group#_____

Policyholder DOB___/___/___
SS#_____
Subscriber Employer_____

Medical Insurance Information

Policy Holder _____

Ins. Company_____

Address_____

Policy#_____ Group#_____
Policyholder DOB___/___/___

SS#_____

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

- **FULL PAYMENT IS DUE AT TIME OF SERVICE**
- **WE ACCEPT CASH, CHECK, VISA, DISCOVER, AMERICAN EXPRESS & MASTERCARD**
- **INTEREST FREE PAYMENT THROUGH CARE CREDIT (with approved credit see brochure)**

For our patients who have dental insurance:

WE ARE AN IN NETWORK PROVIDER FOR CIGNA PPO, MET LIFE, DELTA & AMERITAS. For these three companies we are able to **estimate** your co-pay and ask you pay this co-pay at the time of service.

WE ARE OUT OF NETWORK FOR ALL OTHER INSURANCE COMPANIES.
We require payment in full for all appointments. As a courtesy to you, we will file your claim with your insurance company for reimbursement to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and/or necessary under your dental/medical insurance. You are responsible for all charges regardless of insurance coverage.

Medicare and Medicaid *WILL NOT* cover any services provided by Dr. Mark Petryna. We are not an in network provider. If you have either of these insurances you will be responsible for all charges.

MINOR PATIENTS
The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied.

MISSED APPOINTMENTS
***Unless cancelled at least 24 hours in advance, our policy is to charge for missed surgical appointments at the rate of* $150.00.** Please help us serve you better by keeping scheduled appointments.

INTEREST
We reserve the right to charge interest in the amount of 1.5% as provided by state law.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. If you have questions regarding your account, please contact us at (704) 847-7799. Many times, a simple telephone call will clear any misunderstandings.

I have read the Financial Policy. I understand and agree to this Financial Policy. I hereby authorize my insurance company to assign benefits to Mark M. Petryna, DDS, PA., unless I am paying in full, benefits from my insurance will be paid to me.

X_____ Date_____
Signature of Patient or Responsible Party

MEDICAL HISTORY

Name _____ Age _____

Physician_____Dentist_____

1. Have you been a patient in the hospital during the past two years? (Circle one) YES NO
2. Have you ever had any operations or surgical procedures? YES NO
   Please list _____
3. Have you been under the care of a medical doctor during the past two years? YES NO
4. Have you taken any medicine or drugs during the past two years? YES NO
   Please list: _____
5. Are you allergic to, or made sick by, Penicillin, Aspirin, Codeine, any drugs or medications, or latex? (i.e. itching, rash, swelling of hands, feet or eyes? YES NO
   Please list:_____
6. Have you ever been put to sleep, had general anesthesia or sedation? YES NO
7. Have you or any family member had a serious reaction or fever from an anesthetic? YES NO
8. Have you ever had any excessive bleeding requiring special treatment? YES NO

9. Do you smoke? _____ Packs per day? _____ How long? _____
10. Do you use snuff or chew tobacco?_____ How long?_____
11. **Do you use Recreational Drugs?** _____ **How often?** _____
12. Do you drink beer, wine or liquor? _____ How often? _____
13. **Do you have a Gag Reflex?** _____

Circle any of the following which you have had or have at present:

Asthma
Bronchitis
Pneumonia
Emphysema
Breathing problems
Cough Tuberculosis
Hay Fever
Shortness of breath
Heart disease Heart
Attack
Heart failure Angina
(Chest pain)
Rheumatic Fever
Mitral Valve Prolapse
Heart Murmur
Artificial Heart Valve
Irregular Heartbeats
Palpitations Pacemaker
Heart Surgery
High Blood Pressure
Fainting or dizzy spells
Poor circulation
Bleeding problems
Bruise easily
Anemia

Kidney Trouble
Bladder Infection
Glomerulonephritis
Stomach problems
Ulcers
Glaucoma
Diabetes
Thyroid disease
Growth disturbance
Sarcoidosis
Cortisone injections
Steroid therapy
Hormone replacement
Lupus
Arthritis
Rheumatism
Artificial Joint (Replacement)
Stroke
Epilepsy or seizures
Headaches
Nervous or Anxious feelings
Hepatitis (Infectious or serum)
Liver Disease
Yellow Jaundice
Blood Transfusion
Immune Disease

(PLEASE TURN OVER TO COMPLETE)

Sickle Cell Disease
Hemophilia
Blood Disease
Depression
Mental Illness
Psychiatric Treatment
Counseling
Drug or Alcohol Abuse

HIV, AIDS or ARC
HIV Test: Results_____
Venereal Disease
Gonorrhea
Syphilis Genit8l
Cold Sore/Fever Blister Cancer

14. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest or because you are very tired? YES NO

15. Do your ankles swell during the day? YES NO

16. Do you use more than two (2) pillows to sleeps? YES NO

17. Do you have Sleep Apnea? YES NO

18. Do you ever wake up from sleep feeling short of breath? YES NO

19. Have you lost or gained more than 10 pounds in the past year? YES NO

20. Are you on a special diet? YES NO

21. Has your medical doctor ever said you have a cancer or tumor? YES NO

22. Do you have any disease, condition or problem not listed? YES NO

Please specify:_____

23. WOMEN/FEMALE: Are you pregnant now? YES NO

Are you taking birth control pills? YES NO

Do you anticipate becoming pregnant? YES NO

Do you have children? Number____ YES NO

Were there any delivery complications? YES NO

To the best of my knowledge, all of the preceding answers are true, complete and correct. If I ever have any change in my health or medications, I will inform the doctor at the next appointment. I request and consent to examination, records and photographs advisable in the doctor's opinion ,which will be used only for patient care, education, research, or consultation with other health care professionals, I understand that informed consent will be given prior to any surgical procedure.

_____ _____
SIGNATURE (PATIENT OR GUARDIAN) Date

(Tobe completed by clinic)

SUMMARY
ASA MEDICAL PROBLEMS MEDICATIONS

I.

II.

III.

IV.

_____ _____
BP WT

_____ _____
PULSE RESP

ALLERGIES:

_____ _____
SIGNATURE OF DOCTOR Date

Mark M. Petryna, DDS, PA
Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

MARK M. PETRYNA, DDS, PA is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays Other_____
☐ Spouse (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Parent (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Breach notification ☐ General Dentist/Specialists
☐ For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised August 2013

Mark M. Petryna, D.D.S.

Acknowledgement of Posted Privacy Practices

Patient Name & Address: _____

_____

_____

I acknowledged upon request that I can receive a copy of the Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of the Notice of Privacy Practices because:

- An emergency existed and a signature was not possible at this time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

  _____
- Other: _____

  _____

Prepared By: _____

Signature: _____

Date: _____