JAMES A. OSHETSKI, DDS

IMPLANT AND RESTORATIVE DENTISTRY

PATIENT INFORMATION

Patient Name	Prefix (circle one): Mr. / Mrs. / Ms.	Preferred Name/ Pronoun
Date of Birth	Social Security #	Marital Status
Mailing Address		
City	State	Zip

CONTACT INFORMATION

Please check your preferred contact number

☐ Home	☐ Cell	☐ Work
Email address	Statement Preference: E-Statement / Mailed Statement	

REFERRAL INFORMATION

☐ Website/Internet	☐ Dentist/Doctor	☐ Work in building	☐ Existing patient

If referred, please provide their name so that we may thank them:

IN CASE OF AN EMERGENCY

Please provide the name of a local friend or relative

Emergency Contact Name	Relationship to patient
Home Phone	Cell Phone

INSURANCE INFORMATION

Please give your insurance card to the receptionist

Name of primary dental insurance company	Employer	
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security #
Group Name	Group #	Subscriber Id#
Patient's relationship to Subscriber: Self / Spouse / Child / Other		
Name of Secondary dental insurance company **(If Applicable)**	Employer	
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security #
Group Name	Group #	Subscriber Id#
Patient's relationship to Subscriber (Please circle one): Self / Spouse / Child / Other		

Patient Signature: _____ Date: _____

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DENTAL HISTORY

Patient Name: Date:

Please list any dental problems or concerns:

If you are a new patient, when was your last dental visit? | Name of previous dentist:

Does dental treatment make you nervous?

☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Have you ever had the following for dental treatment?

☐ Nitrous Oxide (Laughing gas) ☐ Intravenous sedation ☐ Oral sedation

MEDICAL HISTORY

Name of your Primary Care Physician/Practice Name

Preferred Pharmacy

Have you ever had ANY of the following? Please circle all that apply

Heart Disease
Rheumatic Fever
Heart Attack (When)_____
Stroke (When) _____
Arrhythmia
Congenital Heart Defect
Angina/Chest Pain
High Blood Pressure
High Cholesterol

Pacemaker
Anemia
Bleeding Disorder
Thyroid Disease
Hepatitis A, B, or C
HIV/AIDS
Liver Disease
Kidney Disease
Diabetes- A1C _____
Pregnancy

Dementia
Alzheimer's Disease
Acid Reflux
Asthma
COPD
Sleep Apnea/ CPAP
Sinus Problems
Psychological Disorder
Anxiety
Depression

Tuberculosis
Cancer (when/type) _____
Fainting/ Dizziness
Osteoporosis/ Bisphosphonates
Radiation/ chemotherapy
Artificial Joints (When) _____
Epilepsy/Seizures
Glaucoma
Other: _____

Do you or have you ever taken oral or IV Bisphosphonates for <u>osteoporosis</u> or chemotherapy? (Boniva, Fosamax, Zometa, Aredia, or Didronel)

☐ Yes If yes, length of treatment: ☐ No

Have you had ANY serious illness or surgery in the last 2 years?

☐ Yes (If yes, please explain) ☐ No

List ANY medications that you take including prescription, non-prescription, supplements, vitamins, herbals, pain & anti-inflammatories.

Name of medication	Reason for use	Dosage and frequency

Please list ALLERGIES:

SOCIAL HISTORY

For your health & safety, please provide your social history and ANY use of recreational drugs.
<u>Failure to disclose will result in immediate dismissal</u>

ALCOHOL Do not use _____ drinks daily _____drinks weekly

TOBACCO Do not use Method: *cigarette pipe vape chew* Frequency of use: _____daily

MARIJUANA Do not use Method: *cigarette pipe edible tincture vape* Frequency of use: _____ daily

RECREATIONAL DRUGS Do not use Name of drug(s) and method of use: _____ Frequency of use: _____

Have you ever been diagnosed with drug or alcohol addiction? Yes No

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TMJ (Temporomandibular Joint) Health Questionnaire

Please check all that apply:

- ☐ Pain in Jaw
  - ○ Right
  - ○ Left
- ☐ Pain While Chewing Gum
- ☐ Pain Chewing a Bagel
- ☐ Noise in Jaw Joint
- ☐ Can Make Jaw Pop or Crack
- ☐ Tired Jaw After a Big Meal
- ☐ Avoid Eating Certain Foods
- ☐ Difficulty Opening Wide
- ☐ Difficulty Yawning
- ☐ Dizziness
- ☐ Feel Faint
- ☐ Nausea
- ☐ Jaw Aches When Opening Wide
- ☐ Allergies
- ☐ Pain in Eyes
- ☐ Hearing Loss
- ☐ Itchiness or Stuffiness in Ear(s)
- ☐ Ringing, Buzzing, Hissing in Ear(s)
- ☐ Sinus Trouble

- ☐ Headaches
  - ○ Right Temple Area
  - ○ Left Temple Area
  - ○ Front of Head
  - ○ Back of Head
- ☐ Migraines
- ☐ Neck Pain
- ☐ Stiff Neck Muscles
- ☐ Chronic Shoulder or Back Pain
- ☐ Clench Teeth
  - ○ Day
  - ○ Night
- ☐ Grind Teeth During Sleep
- ☐ Trouble Sleeping Soundly
- ☐ Sore Teeth When You Wake
- ☐ Sore Jaw When You Wake
- ☐ Wisdom Teeth Removed
- ☐ Pain in around, behind either eye
- ☐ Blurred vision at times
- ☐ Snore
- ☐ Sleep Apnea
- ☐ Sleep Study Completed

Please describe your chief TMJ concern(s):

_____

_____

_____

When did the symptoms begin? _____

Do you take any medications for pain management? _____

If yes, what do you take and how often do you take it? _____

Does anything make your symptoms feel better? _____

☐ I am not experiencing any of the symptoms listed above.

Patient Name: _____ Date: _____

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Authorization to Release & Discuss Dental Information

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians unless we have authorization in writing by the patient to communicate with others on their behalf. Family members, including spouses, are not automatically included; their names must be explicitly stated. If you would like to select an authorized person(s) to communicate with the office of James A. Oshetski **that is not yourself,** please indicate so below.

I give the following named person(s) authorization to take messages or speak with the office of James A. Oshetski, DDS, LLC, on my behalf regarding topics selected below.

Name of authorized person(s): _____

Relationship: _____ Phone number: _____

Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance ☐

Other (explain) _____

-OR-

You may opt out by checking the "Do NOT Release Information" box below.

☐ **DO NOT RELEASE INFORMATION TO ANYONE.** I understand that my express consent is required to release any health care information.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Printed Name: _____

Signature of Patient/Legal Guardian: _____

Date Signed: _____

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CONSENT FOR SERVICE & PAYMENT

I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. Despite the most diligent care and precaution, unanticipated complications or unintended results, although rare, may occur. A treatment plan is based on the best evidence available during the examination. There is no guarantee that this plan will not change. During treatment, it may be necessary to change or add procedures because of conditions that were not evident during examination but were found during the course of treatment. Any changes in treatment plan may result in additional fees.

Treatment Recommendations are based on information gained from diagnostic procedures and examination and may vary for similar situations. The goal of treatment is to assist you in attaining optimum dental health and appearance. We will discuss with you the most appropriate and ideal treatment plan as well as reasonable alternative treatment plans. We will also inform you of the likely dental prognosis for each of these treatment plans and dental prognosis if no treatment is initiated at this time.

Upon such diagnosis, I authorize Dr. Oshetski, Dr. Brunacini or the designated staff person to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I authorize any necessary care and treatment such as: examination, laboratory testing and or procedures, administration of local anesthetics, medication and treatment as directed by my dentist or treating practitioner. I acknowledge that no guarantees have been made to me as to the effort of such examinations, tests, procedures, or treatment of my condition.

By providing contact information I consent to have you, or staff members contact me regarding appointments through U.S. Mail, text, e-mail, and or voice messages at home or at work.

I consent to photography, video recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I authorize the release of any information related to dental claims.

I understand that I am responsible for knowing the terms and conditions of my insurance coverage. I further understand that I may be responsible for obtaining prior authorization for certain procedures for my insurance company to pay for those services. I understand that I am personally responsible for payment, and it is my responsibility to ensure that reimbursement is received from my insurance company. As a courtesy James A. Oshetski, DDS will accept payment directly from your insurance company; however ultimately your account and any unpaid balance is the patient's responsibility.

In consideration of services rendered by James A. Oshetski, DDS, I guarantee prompt payment for services at the time they are provided. I am aware that because of direct billing to my insurance company, I will be asked to pay my estimated portion on the date of service. Any unpaid balances will be billed upon receipt of insurance. Payment must be received within 30 (thirty) days from the receipt of the statement. If unpaid for 90 days, a first attempt to contact me will be made via phone or email. If unsuccessful I will receive a final attempt to collect a debt letter. After 30 days if my account remains unpaid my balance will be sent to a collection's agency and if so, I agree to pay all reasonable costs including attorney's fees and/or collection fees in addition. Once my account is sent to a collection agency, my patient-doctor relationship is terminated. If I have other family members on my account, the balances for each responsible party will be sent separately.

By signing this form, you will consent to our use and disclosure of your protected health information to conduct treatment, payment activities, and healthcare operations.

Print Patient Name _____

Signature of Patient, Parent or Guardian _____

Relationship to patient _____

Date _____

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APPOINTMENT CANCELLATION POLICY

Initials: _____ When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advanced notice of 24 hours**. We understand that conflicts arise; however, failing your appointment or canceling without adequate notice will result in a $100 per hour charge for a hygiene appointment, a $200 per hour charge for a general doctor appointment, and a $500 charge for sedation/surgical appointments and may result in discontinuation of service.

NOTICE TO PATIENTS WITH INSURANCE

Initials: _____ We are happy to process any insurance claim as a service to you at no charge. We are proud that our fees reflect the time that the doctor spends with each patient as well as the overall quality of care and service that we provide in our practice. We are an out-of-network provider, and our fees are not based upon any insurance schedules or allowances. Please be aware that your insurance policy is a contract between you and the insurance company. Also, please be aware that any estimate we provide to you is only an estimate and that you are responsible for all fees in their entirety at the time of your visit.

HEALTH CARE INSURANCE PORTIBILITY & ACCOUNTABILITY ACT

Acknowledgement of Receipt of Notice of Privacy Practices

***You may refuse to sign this Acknowledgement**

A copy of this office's Privacy Practices is posted and is provided on request regarding healthcare information as required by Federal Regulation. Alternatively, I have also been informed that there is a copy posted for viewing in the reception area.

_____ _____

Print Patient Name Signature of Patient, Parent or Guardian

_____ _____

Relationship to patient Date

For Office Use Only

We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication Barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (please specify):

_____

_____

_____