

HEALTH HISTORY

PHYSICIANS NAME _____ PHONE # _____

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING: _____

PLEASE CHECK YES OR NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO	
___	___	AIDS/HIV	___	___	DIFFICULTY BREATHING	___	___	MITRAL VALVE PROLAPSE
___	___	ABNORMAL BLEEDING	___	___	EMPHYSEMA	___	___	PACE MAKER
___	___	ALLERGIES	___	___	EPILEPSY	___	___	PSYCHIATRIC PROBLEMS
___	___	ANGINA PECTORIS	___	___	FAINING OR DIZZINESS	___	___	RADIATION TREATMENT
___	___	ANEMIA	___	___	GLAUCOMA	___	___	REFLUX
___	___	ARTHRITIS, RHEUMATISM	___	___	HAY FEVER	___	___	RHEUMATIC FEVER
___	___	ARTIFICIAL HEART VALVES	___	___	HEADACHES	___	___	SEIZURES
___	___	ARTIFICIAL JOINTS	___	___	HEART MURMUR	___	___	SHINGLES
___	___	ASTHMA	___	___	HEART ATTACK	___	___	SICKLE CELL ANEMIA
___	___	BLOOD TRANSFUSION	___	___	HEMOPHILIA	___	___	SINUS TROUBLE
___	___	CANCER	___	___	HEPATITIS TYPE _____	___	___	STROKE
___	___	CHEMICAL DEPENDENCY	___	___	HERPES/FEVER BLISTERS	___	___	THYROID PROBLEMS
___	___	CHEMOTHERAPY	___	___	HIGH BLOOD PRESSURE	___	___	TUBERCULOSIS
___	___	COLITIS	___	___	KIDNEY DISEASE	___	___	ULCERS
___	___	CONGENITAL HEART DEFECT	___	___	LIVER DISEASE	___	___	VENEREAL DISEASES
___	___	COUGH PERSISTENT/ BLOODY	___	___	LOW BLOOD PRESSURE	___	___	USED "FEN-PHEN"
___	___	DIABETES	___	___		___	___	CIGARETTE, PIPE, CIGAR USE

ALLERGIES

YES	NO		YES	NO	
___	___	ASPIRIN	___	___	METALS
___	___	BARBITURATES	___	___	PENICILLIN
___	___	CODEINE	___	___	SULFA
___	___	DENTAL ANESTHETICS	___	___	TETRACYCLINE
___	___	ERYTHROMYCIN	___	___	OTHER
___	___	JEWELRY	PLEASE LIST _____		
___	___	LATEX	_____		

FEMALES ONLY

YES	NO		YES	NO							
___	___	ARE YOU TAKING BIRTH CONTROL?	___	___							
___	___	ARE YOU NURSING?	___	___							
___	___	ARE YOU PREGNANT? # OF WEEKS _____	___	___							
___	___	ENTERED MENOPAUSE	___	___							
<u>PLEASE CIRCLE THE MEDICATIONS YOU HAVE USED ORALLY?</u>											
___	___	ACTONEL	___	___	BONIVA	___	___	DIDRONEL			
___	___	FOSAMAX	___	___	FOSAMAX PLUSD	___	___	SKELID			
___	___	<u>INTRAVENOUSLY?</u>	___	___	AREIDIA	___	___	BONEFOS	___	___	ZOMETA
PLEASE CONSULT YOUR DENTIST ABOUT COMPLICATIONS WITH THESE MEDICATIONS AND ORAL SURGERY											

FINANCIAL POLICY

REGARDING PAYMENT

Payment is due at time of service. We accept Cash, Checks, VISA & MC. There is a \$25 fee on all returned checks. We offer Care Credit for affordable financing and participate with several discount dental fee programs.

REGARDING CONTRACTED INSURANCE

WE SUBMIT DENTAL CLAIMS WITH ANY CONTRACTED INSURANCE COMPANY AS A COURTESY TO YOU. Please be sure we have your current insurance information for primary, secondary, etc at all times. Dental insurance and the type of benefits you receive are based on a negotiated contract between your employer and the dental insurance companies not your dental office. Some services you need or want may not be covered by your dental benefit plan. Our goal is to help you achieve and maintain optimal dental care; we will not compromise your care based on restraints placed by an insurance policy.

REGARDING NON-CONTRACTED INSURANCE

Payment is due in full at the time of service for patients who have a non-contracted insurance policy. We will provide you with all necessary claim forms and information to file your claim for reimbursement. Please be sure we have your current insurance information at all times.

REGARDING CHILDREN

Children under the age of 18 **MUST** have a parent/guardian present for the entirety of their first dental visit. You may elect to sign a consent for another responsible adult to accompany them on subsequent visits. No exceptions can be made.

I request and authorize Dr. Koren and/or his associates and assistants to examine, clean and provide my/the patient's dental treatment as necessary. I further request and authorize the taking of dental x-rays/photographs as may be considered necessary for diagnostic or educational purposes. I understand that this office only uses composite (tooth-colored) filling material to restore teeth and amalgam (silver) is not available. I will be responsible for any charges incurred on this account.

REGARDING HIPPA

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing below you are acknowledging you have received a copy of the HIPAA privacy handout.

REGARDING MISSED APPOINTMENTS

Your scheduled appointment is reserved just for you. We confirm appointments one (1) week prior to your appointment. We also offer a 24-48 hour courtesy reminder phone call for your confirmed appointment. If you receive a call or post card it is your responsibility to return our confirmation calls. You automatically forfeit your reserved appointment if you fail to confirm. In order to serve you and all our patients we request the courtesy of 2 business days if you need to change your appointment. We recognize that emergencies do occur but abuse of our time could result in being terminated from our practice. Please help us serve you better by keeping all scheduled appointments.

REGARDING MEDICAID INSURANCE

You **MUST** bring your current Medicaid Insurance Card with you to each appointment along with your \$3.00 co-pay if you are 21 years of age and older. If you have not received your current months Medicaid Insurance Card please call the office so a phone verification can be done prior to your appointment. This will save you valuable time for all parties involved.

Signature _____ Date _____

BENJAMIN KOREN D.D.S., P.A. & ASSOCIATES

PATIENT INFORMATION

DATE _____
PATIENT _____
FIRST MIDDLE LAST
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME _____ WORK _____ CELL _____
SS# _____ DATE OF BIRTH _____ AGE _____ SEX M _____ F _____
MARITAL STATUS _____ SPOUSE NAME _____ CONTACT # _____
EMPLOYER _____ HOW DID YOU HEAR ABOUT OUR OFFICE? _____

IN CASE OF EMERGENCY, CONTACT (SPECIFY SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD)

NAME _____ RELATIONSHIP _____
HOME _____ WORK _____ CELL _____

PLEASE COMPLETE IF PATIENT UNDER 18 YEARS OF AGE

PARENT/GUARDIAN _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME _____ WORK _____ CELL _____
DATE OF BIRTH _____ SS# _____

DENTAL INSURANCE

POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____
EMPLOYER _____ INSURANCE COMPANY _____
POLICY HOLDER SS# _____ DATE OF BIRTH _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents), have insurance coverage with _____ and assign directly to Benjamin Koren, DDS, PA, & Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Benjamin Koren DDS, PA & Associates may use my health care information and may disclose such information to the above mentioned insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will remain in affect for as long as I am a patient of record.

Signature of Patient, Parent or Guardian

DENTAL HISTORY

REASON FOR TODAYS VISIT _____
DATE OF YOUR LAST DENTAL VISIT _____ DATE OF MOST RECENT X-RAYS _____
HOW OFTEN DO YOU FLOSS _____ HOW MANY TIMES PER DAY DO YOU BRUSH YOUR TEETH? _____
ARE YOU INTERESTED IN WHITENING YOUR TEETH? _____
ARE YOU INTERESTED IN REPLACING YOUR OLD METAL FILLINGS WITH MORE AESTHETIC TOOTH COLORED FILLINGS? _____

YES	NO		YES	NO		YES	NO	
___	___	BAD BREATH	___	___	FOOD COLLECTION BETWEEN TEETH	___	___	ORTHODONTIC TREATMENT
___	___	BLEEDING GUMS	___	___	FOREIGN OBJECTS	___	___	PAIN AROUND EAR
___	___	BLISTERS ON LIPS OR MOUTH	___	___	GRINDING TEETH	___	___	PERIODONTAL TREATMENT
___	___	BURNING SENSATION OF TONGUE	___	___	GUMS SWOLLEN OR TENDER	___	___	SENSITIVITY TO COLD
___	___	CHEW ON ONE SIDE OF MOUTH	___	___	JAW PAIN OR TIREDNESS	___	___	SENSITIVITY TO HEAT
___	___	CLICKING OR POPPING JAW	___	___	LIP OR CHEEK BITING	___	___	SENSITIVITY TO SWEETS
___	___	DRY MOUTH	___	___	LOOSE TEETH OR BROKEN FILLINGS	___	___	SENSITIVITY WHEN BITING
___	___	FINGERNAIL BITING	___	___	MOUTH BREATHING	___	___	SORES OR GROWTHS
			___	___	MOUTH PAIN, BRUSHING	___	___	EVER WHITENED YOUR TEETH