WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: __/__/__ Age:_____ SS #: _____

Home Address: _____
APT/CONDO #:

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Cell #: (____) _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Contact #: (____)_____ Ext: ____ SS #: _____

Birthdate: __/__/__ Driver's License #: _____

Person Responsible for Account: _____

Contact #: (____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 Insurance Coverage

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____) _____

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol / Drug Abuse	Y	N	Herpes / Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+ / AIDS
Y	N	Artificial Bones / Joints / Valves	Y	N	Hospitalized for Any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer /Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Treatment
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic / Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Metals
Y	N	Codeine	Y	N	Jewelry	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Tetracycline

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature **Date**

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____

Signature **Date**

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ **Date:** _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____
2. Date: _____ Comments: _____ Signature: _____
3. Date: _____ Comments: _____ Signature: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Your Insurance Company may determine that the procedures or services provide for you by this office are not deemed dentally necessary or are non-covered services. It is possible that your insurance may deny payment based on any of the following:

The procedure is considered a **cosmetic service.**

The procedure is a **non-covered service** under your dental plan.

We are **not** a contracted provider with your insurance carrier.

You did **not** obtain a required referral from your insurance carrier.

If your insurance carrier denies payment for the services provided by this office for any of the reasons stated above, you agree to be personally and fully responsible for payment.

A service charge of 1½ per month (18% per annum) on the unpaid balance will be charged on all +9accounts exceeding 90 days, unless previously written financial arrangements are satisfied. Accounts not settled within 90 days will be sent to collection with a charge equal to 35% of the balance being added to the account to recover legal fees and collection costs.

I understand that the fees estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the value of said services shall be as billed. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

PLEASE NOTE: A 24-HOUR NOTICE IS REQUIRED FOR ALL MISSED APPOINTMENTS. OUR OFFICE POLICY IS $75.00 FOR EVERY SCHEDULED HOUR MISSED. NO EXCEPTIONS.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

PRIVACY NOTICE

Our Privacy Promise to You

Dr. John Koot's office provides this notice to you to explain how we may collect information about you (and your member or employees) and what we will do with the personal information, financial information and health information (collectively referred to as the "protected information") that we may receive directly from you, your healthcare provider or any other source in the normal course of health care operations. Dr. John Koot's office is concerned about protecting the privacy of our customers and will use our best efforts to safeguard your protected information.

What types of information will we be collecting?

Dr. John Koot's office collects information from you as required for our business and pursuant to regulatory requirement. Without it, we cannot provide our services for your organization. We collect protected information, including but not limited to, from:

- Claims and Explanation of Benefit Form, such as name, address, and Social Security Number
- Your transactions with us or with other affiliated business partners, such as medical and demographic information.

What will we do with your protected information?

The information Dr. John Koot's office gathers is used only to carry out our duties in complying with our contract with you to assist in health care operations. It is our policy not to disclose any protected information about our customers or former customers or their customers to anyone except as necessary in the normal course of our business. Dr. John Koot's office does not sell protected information to third parties nor do we sell or share customer lists.

Confidentiality and Security

At Dr. John Koot's office, we are committed to the confidentiality and security of your protected information. We restrict access to the protected information to those employees or agents who need to know that information to provide you with our services or otherwise conduct business. We maintain physical, electronic, and procedural safeguards that comply with the federal and state regulations to safeguard all of your protected information.

I, _____, have read and understood the office's

privacy policy.

Signature: _____

Signature of parent or guardian: _____

Date: _____

COVID19 PANDEMIC DENTAL TREATMENT CONSENT FORM

I,_____ knowingly and willingly consent to have dental treatment completed during the Covid19 pandemic.

I understand the COVID 19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

Dental procedures create water spray. It is unclear as to how long the ultra – fine nature of the spray may linger in the air, which can transmit the COVID19 virus.

I confirm that I am not presenting any of the following symptoms of COVID 19 listed below:

FEVER

SHORTNESS OF BREATH

LOSS OF SENSE OF TASTE AND SMELL

DRY COUGH

RUNNY NOSE

SORE THROAT

I understand that air travel significantly increases my risk of contracting and transmitting the COVID 19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry.

I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID19.

I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days.

Name_____ Date_____