



116 Belmont Street, Suite 23
Worcester, MA 01605
Phone: (508)755-0751
Fax: (508)755-5532
KozicaDental@verizon.net
www.KozicaDental.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

I have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify):



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Consent for Treatment and Financial Agreement

Consent for Treatment

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care. I agree to the use of anesthetics and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patients with Insurance

I understand that any expected payment from my insurance company is an estimate only and that I am responsible for any portion not covered by insurance. I further understand that my estimated portion must be paid in full on the day of the treatment. Any amount not covered by the insurance company is due and payable in full immediately upon notification by the insurer. It is my responsibility to verify my coverage. If payment is not completed as agreed and communication has not been made with the office, Kozica Dental will be forced to turn my account over to a collection agency. All collection charges shall be paid by me (the patient), and Kozica Dental shall not be held liable for any damage to my credit rating.

Patients without Insurance

I understand that payment is expected at time of service. I further understand that any portion not paid at this time is my responsibility. If payment is not completed as agreed and communication has not been made with the office, Kozica Dental will be forced to turn my account over to a collection agency. All collection charges shall be paid by me (the patient), and Kozica Dental shall not be held liable for any damage to my credit rating.

Non-Covered Services and Covered Services

I understand that I am responsible for paying for any services not covered by my insurance company. This includes, but is not limited to, fees for amalgam filling removals, whitening procedures, cosmetic procedures such as veneers, and dental nightguard appliances.

For services covered by my insurance, I understand that there is usually a portion of the fee not reimbursed by insurance and that I am liable for paying for the unreimbursed portion of my bill.

PLEASE TURN OVER AND SIGN



Late Fees

For balances over 30 days, a minimum monthly finance charge of \$5.00 will apply to all balances of \$350.00 or less, and a monthly finance charge of 1.5% will apply to all balances over \$350.00. Fees are subject to change.

Cancellation Fees

It is the policy of this office to charge a \$75.00 fee for the time reserved for patients who miss an appointment or cancel with notice of less than 48 business hours. Fees are subject to change.

Outstanding Balances

I understand that if I have an outstanding balance after insurance payment or non-payment is received, that I am responsible for paying my balance in full before I receive new treatment.

Note About Amalgam Filling Removals

If you have decay on a tooth with an amalgam filling, it is our practice to remove the amalgam and then fill the tooth with a composite resin. This involves two procedures: 1.) to safely remove the amalgam filling, and 2.) to fill the decayed tooth with composite resin.

Our office is certified in and follows the SMART (Safe Mercury Amalgam Removal Technique) protocol, which requires additional appointment time and the use of special equipment; therefore, we assess a \$75.00 fee in addition to the normal fee for the filling. Currently, amalgam removal is not a covered insurance expense; therefore, we bill insurance only for the filling. The patient is responsible for the entire amalgam removal filling fee. Fees are subject to change.

Print Name: _____

Patient's Signature: _____ **Date:** _____

Welcome

To help us meet all your healthcare needs, please fill out this form completely.
If you have questions or need assistance, please ask and we'll be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

First Name		MI	Last Name		Date
Street Address		City		State	Zip
Email					
Home Phone		Mobile Phone		Work Phone Ext.	
<input type="checkbox"/> Male <input type="checkbox"/> Female		Check Appropriate Box: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Birth Date		SS #		Driver's Lic #	
Spouse or Parent/Guardian's Name					
If Student, Name of College		City		State	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
Whom May We Thank for Referring You?					
Emergency Contact			Relationship to Patient		
Home Phone		Mobile Phone		Work Phone Ext.	

RESPONSIBLE PARTY

Name of Person Responsible for this Account					
Birth Date			Relationship to Patient		
SS #		Home Phone		Cell Phone	
Address		City		State	Zip
Employer			Work Phone		
Is this Person Currently a Patient in our Office? <input type="checkbox"/> Yes <input type="checkbox"/> No					
We accept cash, check, and credit cards. Please pay your portion in full at each appointment. Would you like us to keep a credit card on file? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate card type here: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover					
Credit Card Number:		Expiration: /		3-Digit Card Verification Code:	

PATIENT DENTAL HISTORY

New Patients Only: Please provide information about your dental history.

Name of Previous Dentist:			Date of Last Exam:		
Previous Dentist's Address/Location:			Date of Last Cleaning:		
Date of Last X-rays (4BWX):			Date of Last Full Mouth X-Rays (FMX):		

PRIMARY DENTAL INSURANCE INFO

If you have dental insurance, please complete the following:

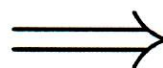
Name of Insured		Insurance Carrier			
Birth Date of Insured		Effective Date:			
Subscriber ID #		Relation to Subscriber : <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other			
Employer Name		Union or Local #			
Employer Address		City		State	Zip
Insurance Carrier Phone		Group #			

SECONDARY DENTAL INSURANCE INFO

If you have *additional* dental insurance, please complete the following:

Name of Insured		Insurance Carrier			
Birth Date of Insured		Effective Date:			
Subscriber ID #		Relation to Subscriber : <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other			
Employer Name		Union or Local #			
Employer Address		City		State	Zip
Insurance Carrier Phone		Group #			

PLEASE TURN OVER AND COMPLETE



Primary Care Physician: _____ Office Phone: _____ Date of Last Exam: _____

	Yes	No		Yes	No
Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been hospitalized for surgery or serious illness within the past 5 years? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking any medications, including non-prescription medications? If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you taken Viagra, Revatio, Cialis, or Levitra in the past 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco or drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Women Only:		
Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant or do you think you may be?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have allergies ? If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
			Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Smoke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Please check Yes or No for the following questions:

	Yes	No		Yes	No
Do you gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sour liquids or foods?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any difficult extractions?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had prolonged bleeding after extractions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck, or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced any of the following problems in your jaw?			Do you wear dentures or partials? If yes, date of placement: _____	<input type="checkbox"/>	<input type="checkbox"/>
			Have you ever received oral hygiene instructions?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking <input type="checkbox"/> <input type="checkbox"/> Pain (joint/ear/side of face) <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening/closing <input type="checkbox"/> <input type="checkbox"/> Difficulty chewing <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf.

X _____ Date _____ X _____
Signature of patient (or parent/guardian if minor) **Doctor's Review Signature**

UPDATES in red

X _____ No changes Date _____ X _____
Patient signature **Doctor's Initials**