Kobza Dental, P.C.
Family and Implant Dentistry

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

Child Information

Name_____Today's Date_____
Last Name First Name Initial
Address:_____Soc Security #_____
City_____ State_____ Zip code _____Home Phone:_____
Date of Birth_____ Mother's Cell Phone: _____Father's Cell phone_____
Mother's Name_____Date of Birth_____ Soc, Security # _____
Mother's Employer_____ Business Phone:_____
Father's Name _____Date of Birth:_____Soc. Security #_____
Father's Employer_____Business Phone:_____
Who does the child live with?_____
Who is responsible for making the appointments_____ Best method of contact _____
Who is responsible for payment? _____Best method of contact _____
Emergency Contact _____Relationship_____Phone Number_____

Primary Insurance

Person Responsible for the Account_____
Last Name First Name Initial
Relation to Patient_____Birthdate_____Soc Security #_____
Address (If different from patient)_____Home Phone_____
City_____State_____Zip_____Cell Phone_____
Person Responsible Employed by_____ Occupation_____
Business Address_____ Business Phone_____
Insurance Company_____Phone_____
Contract #_____Group #_____Subscriber ID_____
Name of other Dependents under this plan_____

Additional Insurance

Subscriber Name_____ Relationship to Patient _____Birthdate_____
Address (if Different)_____Soc. Security #_____
City_____State_____Zipcode_____Home Phone _____Cell Phone_____
Subscriber Employed by_____ Business Phone_____
Insurance Company_____Phone Number_____
Contract #_____Group #_____Subscriber ID_____
Name of dependents under this plan_____

Dental History

What would you like us to do today?_____Do you have any specific dental concerns?_____
Former Dentist_____Address_____
Dentist's email_____ Phone_____
Date of last dental care_____ Date of last x-rays_____
Does your child have any recent toothaches? Yes No Have you been told your child has decay? Yes No
Have they experienced any traumatic mouth injuries? Yes No Any injuries to the teeth? Yes No
Age of 1st Primary tooth:_____ Age of first permanent tooth: _____
Does/Did your child use a pacifier? Yes No Does/Did they suck their thumb? Yes No
Were they bottle-fed? Yes No For how long?_____ Were they breastfed? Yes No For how long?_____
Do they grind their teeth? Yes No Do they snore while sleeping? Yes No Have their tonsils been removed? Yes No
Do you use fluoride toothpaste? Yes No How often do they brush their teeth? _____ Who brushes their teeth? _____
Do they drink juice or pop daily? Yes No Is there sensitivity in the mouth? Yes No If yes, to what?_____

Medical History

Physician's Name: _____Phone Number _____
Date of last visit: _____Have they had any serious illnesses or operations? Yes No
If yes, please describe_____
Are they currently under a physicians care? Yes No If yes, please explain_____
Does your child have a heart murmur? Yes No Heart Condition? Yes No
Have you ever been told your child needs to pre-medicate before a dental procedure? Yes No
Please circle Yes or No if your child has problems with any of the following:

Y N Abnormal bleeding	Y N Convulsions	Y N Hyperactivity
Y N ADHD	Y N Diabetes	Y N Kidney/bladder/liver disease
Y N AIDS/HIV	Y N Ear Infections	Y N Latex Allergy
Y N Arthritis	Y N Eating Disorder	Y N Loss of Consciousness
Y N Anemia	Y N Emotional Problems	Y N Nervous/Anxiety problems
Y N Asthma	Y N Epilepsy	Y N Psychiatric Care
Y N Atopic (allergy prone)	Y N Eye Disorder	Y N Recurrent Headaches
Y N Blood Disease	Y N Hearing Impaired	Y N Seizures
Y N Cancer	Y N Hemophilia	Y N Skin Disease
Y N Chemotherapy	Y N Hepatitis	Y N Stomach Problems (ulcers)
Y N Chronic Sinus	Y N High Blood Pressure	Y N Thyroid disease or malfunction

Please list all current medications: Does the patient have any drug allergies? Please list all:

_____ _____
_____ _____
_____ _____

Authorization

I have reviewed the information on the questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes to the child's medical status, I will inform the dentist.
I authorize the dentist to treat my child and give him or trained members of this staff permission to take x-rays.
I authorize the insurance company, as indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefit. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Parent/Guardian:_____ Date_____

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

Financial Responsibility

Thank you for choosing our office as your dental care health provider. We are committed to your treatment being both a pleasant and successful experience. Please understand that payment for treatment and services rendered is considered part of your treatment. The following policy has been proved instrumental in keeping dental care costs down for our patients by eliminating costly administrative expenses associated with billing procedures.

Fees for treatments are due at the time the treatment is provided. A written estimate of treatment cost will be provided prior to provision of treatment. Payment methods include, cash, check, credit card and a no-interest payment program (CareCredit). A 5% discount will be offered for all payments by cash or check on the same day of service. Returned checks will be assessed a $25 fee and must be paid by cash or money order.

For most dental insurance plans, we will file the insurance for you and will accept payment directly from your dental insurance company. However, dental insurance is a contract between you and your insurance company, and in most cases your dental insurance company will not pay for the entire cost of treatment. Fees not covered by your dental insurance may include deductibles; co-payments or certain procedures deemed "non essential" or "plan exclusions." Through the years our office has learned the level of any dental plan is directly related to the level of payment made to the plan by the policyholder's employer.

We will estimate the benefits of your insurance before each treatment and may collect the estimated portion your insurance company is not expected to pay. We are not responsible for how your dental insurance company processes its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment; we at no time guarantee what your insurance will or will not do with each claim. Some dental insurance companies will not reimburse our office, but will pay dental insurance benefits to you. In this instance, we will file your dental insurance claim for you, and you will be responsible for full payment when treatment is provided.

If your dental company has not provided payment within 30 days after submission of a dental insurance claim, we will notify you in writing and allow you 30 days to complete payment. A finance charge of 1.5% will be added to all invoices over 30 days old. Any account balance remaining unpaid 90 days after provision of treatment may be forwarded to a collection agency and/or attorney for resolution. All costs incurred in collecting unpaid fees will be charged to your account.

Appointment Responsibility

Please arrive at the start of your scheduled appointment time; if you are more than 10 minutes late, you may need to be rescheduled. We allow, "pre-appointing" of routine checkups 6 months in advance of the appointment time if desired, and allow "multiple appointments" for families during the same day. However, upon the first occurrence of failure to show for an appointment, or upon the first appointment change or cancellation less than 24 hours prior to an appointment, we may not allow "pre-appointing" or "multiple appointments" for future appointments. Two or more occurrences of such failure to show for an appointment, or appointment changes or cancellations less than 24 hours prior to the appointment, by an individual or member of the same family may result in dismissal from the practice.

By signing below, I attest that I understand the Financial and Appointment Responsibility statements and agree to honor them.

Signature_____ Date_____

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you the Notice about our privacy practices, our legal duties, and your rights concerning your health information. We just follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect July 12, 2007 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare options: For example:
Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner performance, conducting training programs, accreditation, certifications, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time. You revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other persons to the extent necessary to help with your healthcare or with payment for your healthcare; but only if you agree that we may do so.
Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing us to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of heath information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to military authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminder We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare options, and certain activities, but not before July 12, 2007. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests.
Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.
Alternative Communication: You have the fight to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make the request in writing.) Your request must specify alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Notice of Privacy Practices

I understand that, under the Heath Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers (i.e. insurance, financing companies)
Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received a notice of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree, then you are bound to abide by such restrictions.

Print Patient Name _____

Patient/Guardian Signature_____

Relationship to Patient _____

Date _____