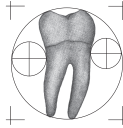


DENTISTRY

THOMAS J. POKSAY, D.M.D.,INC.
330 Ignacio Boulevard Suite 102 Novato, California 94949
ph 415.883.0588 fax 415.883.0591 www.novatodentist.net

GET ACQUAINTED QUESTIONNAIRE

Welcome to our office! We feel you will be pleased with the care you will be receiving. Prior to beginning treatment, the following information is necessary. Please complete fully and PRINT legibly. All information will be held in strict confidence. Thank you for joining our family of patients.

Patient Name: ______________________________ Home Phone_________________ Cell #___________________________
Fax # ______________________________________ E-mail ______________________
Address ____ City__________________________ State______ Zip _________
Soc Sec. No. ____________________________ Birthdate ______________________ Age ___________________________
Patients or Parents Employer ____ Occupation ___________________________
Address ____ Phone ___________________________________ Ext# _____
Spouse or Parents Name:____
If patient is a student, name of school/college:__________________________ City: _______________ State:_____________

If patient is a minor, may we treat him or her in your absence should they come for treatment at a regular appointment and you are unable to accompany them to the office? ☐Yes ☐No, no treatment other than that which is scheduled shall be performed at that visit if you are not present.

Person to contact in case of emergency: ___________________________ Relationship_____________ Phone _____________
Whom may we thank for referring you?____
What is the major reason you are here today? ____

PERSON RESPONSIBLE FOR THIS ACCOUNT OTHER THAN THE PATIENT

Responsible party's Name________________________________ Birthdate _____________ Relationship to Patient__________
Address (if different from above) __________________________ Home Phone _______________________________________
Responsible Party's Employer______________________________ Occupation ___________ Soc. Sec. No. _________________
Business Address _______________________________________ Work Phone _____________________________ Ext. _______
Cell No. ____ Fax No. ____

INSURANCE INFORMATION

Subscriber's Name _____________________________________ Birthdate _____________ Soc. Sec. No./I.D.No.________________
Subscriber's Employer __________________________________ Business Address ____________________________________
Insurance Company ____________________________________ Group/Policy No._____________________________________
Insurance Company Address ____
Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Dependent

ADDITIONAL INSURANCE

Subscriber's Name _____________________________________ Birthdate _____________ Soc. Sec. No./I.D.No.________________
Subscriber's Employer __________________________________ Business Address ____________________________________
Insurance Company ____________________________________ Group/Policy Number _________________________________
Insurance Company Address ____
Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Dependent

ASSIGNMENT & RELEASE

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local anesthetic as may be deemed advisable by the dentist. I hereby authorize my dentist to release any and all dental and medical information to the above-named insurance carrier for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

Scheduled appointment times are reserved just for you. If you are unable to keep your appointment, please let us know at least 48 business hours in advance to avoid broken appointment charges.

I hereby authorize my Insurance Carrier to pay directly to the within-named dentist(s) the dental benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by insurance.

____ _______________
(Patient or parent/guardian if patient is a minor) (Date)

____ _______________
(Responsible Party) (Date)

A MESSAGE ABOUT HEALTH HISTORIES AND DENTAL CARE

Although dentists primarily treat the mouth, head and neck areas, these areas all relate to your overall health. Therefore, it is important for us to know all facts relative to your present and past health. The information you give here is strictly confidential.

MEDICAL HEALTH HISTORY

Name of Physician ___________________________ Address___________________________ Phone___________

Date of last physical examination __________________ ; Medical Record No. _________________

PLEASE MARK YES OR NO TO THE FOLLOWING QUESTIONS

Question	yes	no
Are you now, or have you been, under a physician's care during the past two years?..............................	☐	☐
If so, what conditions were you treated for?____		
Have you had any major illness or operations?..	☐	☐
Please list and give approximate dates____		
Do you take, or have taken, any kind of drugs or medicines during the past year? (including over-the-counter medicines and vitamins?____	☐	☐
If so, what?____		
Have you experienced any adverse or allergic reaction to medications?..	☐	☐
If so, please explain ____		
For Women: Are you pregnant ☐ nursing ☐ taking birth control medication? ☐..................................	☐	☐

Please review the following carefully and check any conditions for which you have been treated.

- ☐ Heart conditions or murmurs
- ☐ Rheumatic fever
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Kidney disorder
- ☐ Cancer or tumor
- ☐ Bleeding or blood disorder
- ☐ Tuberculosis
- ☐ Redux Thereapy
- ☐ Pneumonia
- ☐ Lung or respiratory disease
- ☐ Glaucoma or serious eye disorder
- ☐ Arthritis, bone or joint problem
- ☐ Endocrine (glandular) disorder
- ☐ Asthma
- ☐ Hay fever
- ☐ AIDS/ARC
- ☐ Smoker
- ☐ Fen-Phen Therapy
- ☐ Hepatitis ☐ jaundice ☐ liver disease
- ☐ Prosthetic joint replacement
- ☐ Venereal or other communicable disease
- ☐ Chemotherapy, radiation therapy
- ☐ Fainting ☐ dizziness or ☐ nervous disorders
- ☐ Convulsions ☐ seizures or ☐ epilepsy
- ☐ Psychological problems
- ☐ Frequent fever blisters or cold sores
- ☐ Biophosphonate therapy (fosamax, zometa,aredia)

Please indicate any concerns/conditions not listed above of which you feel we should be made aware____________________

____

DENTAL HISTORY

Previous dentist _________________________________ How long ____

Most recent dental exam __________________________ Most recent dental x-ray__________________________________

Most recent dental treatment ____

How often do you have your teeth cleaned? 3 mo.____ 4 mo. ____ 6 mo.____ 1 year or longer ____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?____

____

____

Are you satified with your past dental care?____

Please mark yes or no to the following questions

Question	yes	no
Are you unhappy about appearance of your teeth?..	☐	☐
Does food catch between your teeth?..	☐	☐
Do your gums feel irritated ☐ swollen ☐ or bleed frequently when brushing? ☐ flossing? ☐	☐	☐
Has periodontal (gum) disease ever been diagnosed? ☐ or treated? ☐	☐	☐
Do you have a bad taste or odor in your mouth?..	☐	☐
Do you have any loose teeth, or have any teeth moved or shifted within the past two years?........................	☐	☐
Do you or have you ever smoked? (packs/day______) When did you quit?_______________	☐	☐
Do you floss, use a water jet device, interdental stimulator, or proxy brush?..	☐	☐

Please mark yes or no to the following questions

	yes	no
Have you lost any teeth?	☐	☐
Are any of your teeth sensitive to hot ☐ cold ☐ sweets ☐ biting ☐ or touch ☐	☐	☐
Do you have toothaches, sore teeth or dental pain?	☐	☐
Do you have any broken teeth, missing fillings or root canals?	☐	☐
Do you have a dry mouth?	☐	☐
Do you drink fluoridated water or take fluoride supplements?	☐	☐
Have you had cavities diagnosed or treated within the past two years?	☐	☐
Have you ever had a dental implant?	☐	☐
Do you clench ☐ or grind your teeth? ☐ Are you awake ☐ or asleep ☐ when it occurs?	☐	☐
Do you have discomfort ☐ soreness ☐ or pain ☐ in your neck ☐ ears ☐ jaw ☐ jaw joint ☐	☐	☐
or side of your face? ☐	☐	☐
Do you get frequent headaches?	☐	☐
Does your jaw ever pop ☐ click ☐ lock ☐ or become fatigued ☐ or tired? ☐	☐	☐
Do you have difficulty opening widely ☐ closing ☐ or chewing ☐ certain types of foods?	☐	☐
Do your teeth come together unevenly ☐ or do you hit one tooth before others when you bite? ☐	☐	☐
Do you wear a splint ☐ nightguard ☐ had an injury to the head ☐ neck ☐ or jaw? ☐	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you dislike the color ☐ of your teeth or have noticeable spots ☐ or stains? ☐	☐	☐
Do you have existing crowns ☐ or dental work which you consider "ugly"? ☐	☐	☐
Do you have chips ☐ spaces ☐ crowded ☐ or crooked teeth ☐ that bother you?	☐	☐
Are you self-conscious of your teeth or smile, has anyone suggest you change your smile?	☐	☐
Would you like to improve your smile?	☐	☐
Have you ever had complications from past dental treatment?	☐	☐
Have you experienced any complications or reactions from local anesthetic?	☐	☐
Have you had teeth extracted?	☐	☐
Did you ever have braces ☐ or orthodontic treatment? ☐	☐	☐
Do you have any lumps ☐ sores ☐ or growths ☐ in your mouth?	☐	☐
Does dental treatment cause you much worry or concern?	☐	☐
Have you had an unpleasant dental experience in the past?	☐	☐
Do you think your teeth are affecting your general health?	☐	☐

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a partial or complete artificial denture, please complete the following
(Please check yes or no)

	yes	no
Has your present denture been relined? When__________	☐	☐
Is your present denture a problem? Describe__________	☐	☐
Satisfied with the appearance?__________	☐	☐
Satisfied with comfort?__________	☐	☐
Satisfied with the chewing ability?__________	☐	☐

When did you receive your first partial or complete denture?__________

How long have you worn your present denture?__________

Patient's Signature__________ Date__________

Doctor's Remarks:__________

__________ Doctor's Signature__________

FOR OUR PATIENTS WITH DENTAL BENEFITS/INSURANCE

As happens in the course of your care, there are occasions when certain dental treatments or procedures are necessary but for which no dental benefit or insurance is available due to your particular insurance plan exclusions.

While we do our best to advise you of these instances in advance of treatment, we do not have detailed knowledge of the dental insurance experts for the hundreds of dental plans our patients have. Your treatment may very well include one or more of the necessary but "not covered benefits" indicated below.

Please be advised the fee for such treatment is your responsibility and payment for such is requested at the time of service.

Thank you for your understanding.

NEEDED DENTAL TREATMENT

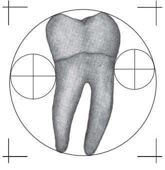
(procedure typically not covered by dental benefit/insurance providers)

- "CariFree" decay susceptibility test
- VelScope oral cancer screen
- Crown build up
- Diagnostic study models
- Functional analysis
- Facebow transfer and mounting
- Other______________________

Name: _______________________________

Signature: _____________________________

Date: ________________________



DENTISTRY

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Financial Policy

Thank you for choosing us for your dental care. We are committed to providing you excellent care, and payment of your bill is part of successful treatment. Our Financial Policy is based on an open discussion of our fees. Our fees reflect our commitment to the quality our patients deserve and can expect.

Please read, sign, and return the following

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE.

The following plans are acceptable means of payment for the treatment you have selected. Please choose the plan best suited to you.

A. CASH/CHECK: You will receive a 5% bookkeeping courtesy for cash or check payment at time of service.
B. CREDIT CARDS: We accept Visa, Mastercard. Cash discounts are not offered for credit card payments as the practice pays a merchant fee on all credit card transactions.
C. 3-PAYMENT PLAN: Three equal payments on balances of $300.00 or more with the first payment due at the time of service, the second at 30 days, and the final at 60 days. A finance charge of 1.5% per month (18% ANNUAL PERCENTAGE RATE) will be assessed.
D. CARECREDIT: Visit our website for your financial needs and more information on CARECREDIT.

Insurance

As a service to our patients, we will bill your insurance company if you bring in completed original insurance forms and all insurance information. Your insurance policy is a contract between you and your insurance company. In the event we accept assignment of your insurance benefits, we require that preapproved arrangements be made on the entire amount. While insurance policies vary and certain services provided may not be covered, our office is committed to helping our patients maximize their benefits. We are always available to answer your questions.

Minors

Payment for treatment of minors is the responsibility of the custodial parent. As we are not a party to any child support/dental expense agreements made between the minor child's parents, we cannot bill the non-custodial parent for services unless prior arrangements are made with our office.

Service Charges

The policy of this office is to charge interest of 1.5% per month (18% ANNUAL PERCENTAGE RATE), which will be applied to all accounts 30 days after treatment date. We will charge $25.00 for returned checks.

Collection Fees

Fees incurred to collect payment will be billed to, and are payable by the patient.

Financial Consent

The patient (or guardian) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement.

Patient's name (print): ______________________________

Patient's signature: ______________________________ Date: __________

—— OVER ——

THOMAS J. POKSAY, D.M.D.,INC.

ACKNOWLEDEGEMENT 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 acknowledgement
- ☐ Other (Please Specify)

____
____
____

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