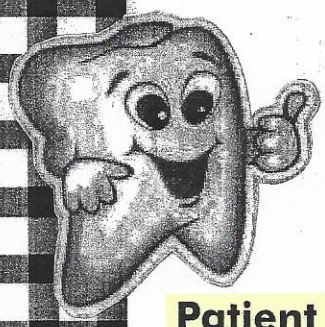
Dr. Andre Kanarki D.D.S.



Welcome

Thank you for selecting us.

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

Patient Information (Confidential)

Name _____ Date _____

SSN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Birthdate _____ SSN _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Care Credit Credit Card ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Over Please

Patients Dental Health

Why have you come to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ Last Visit _____ **Date of last cleaning** _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? ☐ Yes! ☐ No If yes please, tell us why: _____

How often do you brush? _____ Do you floss? ☐ Yes ☐ No **How often?** _____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N My gums feel tender or swollen.
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.

Patients Medical History

Do you have or have you had any of the following? ***Please circle Y for yes or N for no.***

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Pacemaker
7. Y N Stent.
8. Y N Abnormal Blood Pressure
9. Y N Anemia
10. Y N Prolonged Bleeding Disorder
11. Y N Tuberculosis or Lung Disease
12. Y N Asthma
13. Y N Hay Fever
14. Y N Sinus Trouble
15. Y N Epilepsy/Seizures
16. Y N Ulcers
17. Y N Implants/Artificial Joints: Hip-Knee _____ Other _____
18. Y N I smoke or use chewing tobacco. If yes, how much per day?_____ How many years? _____
19. Y N I have consumed alcohol within the last 24 hours.
20. Y N I usually take an antibiotic prior to dental treatment.
21. Y N Have you ever taken Fen-Phen or Redux?
22. Y N Do you take or have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) for Osteoporosis or any other condition?
23. Y N I have had major surgery. Year _____ Type of operation _____ Year _____ Type of operation _____
24. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

25. Y N Liver Disease
26. Y N Jaundice
27. Y N Hepatitis Type _____
28. Y N Diabetes
29. Y N Excessive Urination and/or Thirst
30. Y N Infectious Mononucleosis ("Mono")
31. Y N Herpes
32. Y N Arthritis
33. Y N Sexually Transmitted/Venereal Diseases
34. Y N Kidney Disease
35. Y N Tumor or Malignancy
36. Y N Cancer/Chemotherapy
37. Y N Radiation/Therapy
38. Y N History of Drug Addiction

39. Y N HIV
40. Y N AIDS
41. Y N Immune Suppressed Disorder
42. Y N Hearing Loss
43. Y N Fainting Spells
44. Y N Glaucoma
45. Y N History of Emotional or Nervous Disorders

WOMEN:

46. Y N Are you taking birth control medication?
47. Y N Are you or could you be pregnant or nursing?

Doctor Notes Only:

Are you allergic to any of the following?
Please circle Y for yes or N for no

48. Y N Aspirin
49. Y N Ibuprofen
50. Y N Sulfa Drugs/Sulfites/Sulfides
51. Y N Penicillin
52. Y N Codeine
53. Y N Latex, Metals, Plastics
54. Y N Local Anesthetics (i.e., Novocain, Lidocaine
55. Y N Other Medications Which ones?_____

Please list all medications you are currently taking:

Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Physician's Name _____ Phone _____
Address _____ Fax _____

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by:

X _____ / ____ / ____
Doctor's Signature *Date*

Periodic medical/dental health reviewed by:

X _____ / ____ / ____
Doctor's Signature *Date*

X _____ / ____ / ____
Doctor's Signature *Date*

X _____ / ____ / ____
Doctor's Signature *Date*

X _____ / ____ / ____
Patient's Signature *Date*

X _____ / ____ / ____
Patient's Signature *Date*

X _____ / ____ / ____
Patient's Signature *Date*

X _____ / ____ / ____
If Patient is a minor: must have Guardian's Signature *Date*

Getting To Know You As Our Patient

INFORMED CONSENT

Patient Name: _____

1. **WORK TO BE DONE**

I understand that I am having the following work done: Fillings ☐, Bridge ☐, Crowns ☐, Impacted teeth removed Root Canals ☐, Other ☐, X-Rays ☐, Exam ☐, Prophy ☐ _____ Initials

2. **DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction.)

3. **CHANGES IN TREATMENT PLAN** _____ Initials

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary, after having been informed and in agreement with the changes. _____ Initials

4. **REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. _____ Initials

5. **ANESTHESIA**

I realize the risks involved in receiving an anesthetic, some of which are: upset stomach, dizziness, vomiting, soreness are adverse reactions to drugs causing cardiac arrest, miscarriage, dislodging or chipping teeth and jawbone. _____ Initials

6. **CROWNS, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crown, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. _____ Initials

7. **DENTURE – COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. _____ Initials

8. **ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth and that complication can occur from the treatment and that occasionally metal objects are cemented to the tooth or extended through the root, which does not necessarily affect the success of the treatment. _____ Initials

9. **PERIODONTAL LOSS (TISSUE AND BONE)**

I understand that I have a serious condition causing gum and bone inflammation or loss and that it can lead to the loss of my teeth and other complications. The alternative treatment plans have been explained to me including, gum surgery, replacements and/or extractions. I understand that although these treatments have a high degree of success, it cannot be guaranteed. Occasionally, treated teeth may require extraction. _____ Initials

10. **FILLINGS**

The Dentist has advised me that the silver amalgam/bonding restoration is an acceptable procedure according to ADA guidelines and, as such, is a treatment used by Andre Kanarki, DDS, Inc. The advantages and disadvantages of alternate materials have been explained to me. _____ Initials

I hereby request and authorize the Dentists and their Staff to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissue as explained above. The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me. I also authorize the operating Dentist and Assistants to perform any other procedure, which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation. I know that the practice of Dentistry and surgery is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have requested and authorized. I also understand that it is my responsibility to inform the Dentist if I am having any problems during the following treatment so as to allow him to help minimize and problems.

Alternative and possible reactions have been explained to me clearly and in detail. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Parasthesia), fractured jaw, etc., have been clearly explained to me.

I CERTIFY THAT I HAVE BEEN AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature _____ Relationship _____ Date _____

Doctor _____ Witness _____ Date _____

Our Financial Policy

Please read and sign the following:

Payment in full is due at the time of service. We offer several options of payment for the services we provide.

1. We accept Cash, Visa, MasterCard, Discover and American Express. **NO PERSONAL CHECKS ACCEPTED.**

2. We also offer a financial arrangement through Care Credit, outside financing O.A.C. All patients who wish to use this service must fill out an application and be approved by Care Credit. If patient is not approved, we spread out the treatment until full payment can be made.

FINANCIAL ARRANGEMENTS MUST BE MADE PRIOR TO TREATMENT

Usual and Customary Rates

We are committed to providing excellent dental treatment to all of our patients. Our fees reflect our commitment to the quality our patients deserve and are considered usual and customary for the area. Regardless of any insurance company's determination.

Insurance

As a service to our patients, we will bill your insurance company. Your insurance policy is a contract between you and your insurance company. As a health care provider, we are not party to your agreement with your insurance. Insurance policies vary and services provided may not be covered. The balance is your responsibility whether your insurance pays or not. Our office is committed to helping our patients maximize their benefits. We are always available to answer your questions.

Missed Appointments

One of the ways we keep our fees more affordable is by avoiding broken appointments. We understand that occasionally our patients will need to reschedule their appointments. Please notify us 24 hours prior to your appointment to avoid a **$50.00** charge for canceling the same day as appointment.

I understand and agree to the Financial Policy and Agreement.

_____

SIGNATURE **DATE**

PERMISSION TO TAKE PHOTOGRAPHS, SLIDES, & VIDEO

I, (print name)_____, hereby authorize

Dr. (print name)_____ANDRE KANARKI D.D.S., INC._____to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and will not be shared or publicized in a any way.

I further understand that photographs, slides, and/or videos are kept confidential and are used for identification purposes only.

_____ _____

Patient's Signature If a Minor (Please Print Name) Date

_____

If a Minor, Signature of Parent or Guardian

_____

Doctor Signature

CONSENT FOR LOCAL ANESTHETIC INJECTIONS

I, (print name)_____, hereby authorize

Dentist/Hygienist/Other (print name)___ANDRE KANARKI D.D.S., INC.___ to perform a local anesthetic injection(s).

I understand, and it has been explained to me, that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue at the site of the injection which can not be determined prior to the administration of the anesthetic agent. Although the risks seldom occur they might include loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs it is often temporary, and normal sensation usually returns in several days. However, in very rare cases the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injection(s), I agree to report them to the office as soon as possible.

I have been told that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I have discussed all of the above with the doctor, and have had all of my questions answered.

_____

Patient's Signature If a Minor (Please Print Name)

_____

If a Minor, Signature of Parent or Guardian

_____

Dentist/Hygienist/Other Signature

HIPAA Privacy Rule Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement;
- this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness ……..……..

Printed Name of Individual or Legal Representative ……...

Witness……

Date: ……

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barrier prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Others (please specify)

_____

_____

_____

_____ _____

HIPAA Officer Date

HIPAA Privacy Rule of Patient Authorization Agreement

ANDRE KANARKI D.D.S., INC.

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this faciliy's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient or Legal Representative Witness .....

X Printed Name of Patient or Legal Representative Witness .....

Date: .....