



Center For Cosmetic & General Dentistry

*Welcome to our practice.*

Please take a few moments to complete *both* sides of this form.

### Patient Information

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Number \_\_\_\_\_ Work Number \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Sex: M F Birthdate \_\_\_\_ \ \_\_\_\_ \ \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Patient Employer \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

### Responsible Party (complete only if patient is under 18)

Person Responsible for Account: First Name \_\_\_\_\_ Last \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Home Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_ \ \_\_\_\_ \ \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Work Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

### Insurance Information

Policyholder: First Name \_\_\_\_\_ Last \_\_\_\_\_

Birthdate \_\_\_\_ \ \_\_\_\_ \ \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Relationship to patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home Number: \_\_\_\_\_

Work Number: \_\_\_\_\_ Insurance Company Name: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

### Office Information

For your convenience, we accept cash, personal check, MasterCard, Visa and Discover Card.

We are committed to providing you with the best possible care and we are happy to discuss our professional fees and policies with you at any time. Your clear understanding of these policies are important parts of our professional relationship. Please ask us if you have any questions.

I have read and understand the above. I also confirm that the above information is accurate.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

\*Responsible party if patient is under 18

## Medical History

Physician's Name \_\_\_\_\_ City \_\_\_\_\_

Date of last exam \_\_\_\_\_

Are you currently being treated, or been treated in the last year, other than routine care?

If so, please describe \_\_\_\_\_

Have you ever taken any of the drugs collectively referred to as "fen-phen?" \_\_\_\_\_

(Women) Are you pregnant? \_\_\_\_\_ If so, what trimester? \_\_\_\_\_ Nursing? \_\_\_\_\_

Circle if you have or have had any of the following:

Anemia	Hepatitis	Thyroid Problems
Artificial Joints	High Blood Pressure	Tobacco Habit
Asthma	HIV/AIDS	Tuberculosis
Cancer	Kidney Disease	Venereal Disease
Chemical Dependency	Liver Disease	
Diabetes	Prolonged Bleeding	
Epilepsy	Radiation Treatment	
Glaucoma	Respiratory Disease	
Heart Problems	Rheumatic Fever	
*Artificial Valves	Shortness of Breath	
*Murmurs	Skin Rash or Hives	
*Mitral Value Prolapse	Stroke	
*Pacemaker	Swelling of Feet or Ankles	

List any medications that you are currently taking: \_\_\_\_\_

Are you allergic to any of the following? (please circle any that apply)

Aspirin	Nitrous Oxide
Codeine	Penicillin
Erythromycin	Sulfa Drugs
Latex	Tetracycline
Local Anesthetic	Other: _____

Please list your pharmacy of choice: \_\_\_\_\_

## Dental History

Former Dentist \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Date of last X-rays \_\_\_\_\_ Date of last visit \_\_\_\_\_

Circle if you have had problems with any of the following:

Bad Breath	Grinding teeth	Sensitivity to hot
Bleeding gums	Loose teeth or broken fillings	Sensitivity to sweets
Clicking or popping jaw	Periodontal treatment	Sensitivity when biting
Food collection between teeth	Sensitivity to cold	Sores/growths in mouth

At times it is important to take 35mm and digital photographs as documentation for patient's permanent records. These photos may be viewed by other patients as an illustration and for educational purposes. I authorize release to use my photos.

(Signature) \_\_\_\_\_

## Financial/Office Policies

This is an agreement between Drs. Jan C./Ryan C. Kraska and the patient/debtor named on this form. In this agreement the words “you”, “your”, and “yours” mean the patient/debtor. The word “account” means the account that has been established in your name to which charges are made and payments are credited. The words “us”, “we”, and “our” refer to The Kraska Center For Cosmetic & General Dentistry. By executing this agreement, you are agreeing to pay for all services that are received.

**Monthly Statement:** Our office request payment of your estimated portion, minus insurance, each time that you are seen. If after insurance payments there is still a balance, a statement will be sent. After 60 days, any claim that insurance has still not paid, you will be billed for the entire amount. Finance charges will also begin at this time.

**Payments:** Payment for your treatment is due when services are rendered, unless we have approved other arrangements. Please address any concerns prior to being seen.

**Charges to Account:** We have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid in advance or at the time of service.

**Finance Charge:** A finance charge will be imposed on each item of your account that has not been paid within sixty (60) days of the time the item was added to the account.

**Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If it becomes necessary to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If this account is submitted to an agency, any patient 18 and over assume the responsibility of the account. If under 18, the signing responsible party assumes responsibility.

**Correspondences:** If attorneys regarding accidents or other matters need copies of your chart/records, a fee of \$50.00 will result for each request.

**Waiver of Confidentiality:** You understand if this account is submitted to an attorney or collection agency, or if your past due status is reported to a credit reporting agency, the fact that you received treatment in our office may become a matter of public record.

**Returned Checks:** There is a fee (currently \$30) for any checks returned by the bank. This fee is charged to our office and in turn, passed onto the patient.

\_\_\_\_\_  
initials



**Appointment Confirmations:** Our office uses an automated service to confirm appointments via cell phone, email, pagers, and pda's. This is our main source for appointment confirmations. Since we send text/email, you don't have to answer a call. Simply read it and respond at your convenience. Several messages are sent prior to your scheduled appointment. Please make sure we have current email addresses and cell phone numbers. Please note that cancellations or changes to your appointment cannot be made via email or text.

**Missed Appointment Fee:** Our office does charge for changes or cancellations that take place with less than 48 hours notice. A fee of 10% of the total scheduled treatment\* or a flat fee of \$50.00 will be charged to the account. (Whichever is greater) This fee will need to be paid before a new appointment is scheduled. Patients with two failed appointments may be asked to transfer their records to another dental practice. As mentioned above, changes cannot be made via email or text message.

\*For large case appointments, other terms apply and will be explained at the time of the work-up appointment.

**Effective Date:** Once you have signed this agreement, you agree to the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: \_\_\_\_\_

Responsible Party: \_\_\_\_\_  
(if patient is under 18)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF HIPPA PRIVACY PRACTICES

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

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

## Patients With Dental Insurance

Our office will file all dental claims as a courtesy to our patients and will accept payments from the Insurance Company as long as they allow that. However, ***we are not*** a Participating Provider with any Insurance Company. Your Insurance plan is a contract between you and the Insurance Company. We are not contracted with any plan. What this means for you:

(examples)

Your insurance company pays 100% of a procedure, and our fee is \$76.00. If their UCR allowed amount is \$74.00, then you will owe \$2.00.

Your insurance company pays 80% of a procedure, and our fee is \$349.00. If their UCR allowed amount is \$290.00; they will pay 80% of \$290.00, not \$349.00. You will be responsible for the difference between the \$290.00 and \$349.00 and your 20%. Your total owed would be \$117.00.

Usual, customary, and reasonable (UCR) are the maximum amounts that your plan covers as eligible fees. Although these limits are called “customary” or “reasonable”, they may not reflect the fees that our office charges. **Exceeding the plan’s UCR fee does not mean that our office has overcharged for the procedure.** Since we are not contracted with the insurance company, we honor our fees not theirs.

Insurance companies also have the ability to pay for a least expensive alternative treatment. Even though our Doctors may diagnose and treat an area with a procedure that they feel is the best treatment for the area, your insurance may decide to pay for a least expensive treatment, regardless of your dental need. This will mean more out of pocket for you.

We offer treatment plans to our patients that need dental treatment. This treatment plan will show the fees that we are charging, the estimated insurance benefit, and the total out of pocket you will be responsible for. These figures again are only an ***ESTIMATE***. Your insurance company determines the final payment once they receive your dental claim. Any amount not covered is your responsibility!

If you have any questions regarding your insurance coverage, please ask our Front Office before having any treatment accomplished. It is also your responsibility to inform our office when there has been a change in your insurance policy.

By signing this form, you fully understand your responsibility and accept the terms as listed above.

\_\_\_\_\_  
Patient or Responsible Party (if under 18)

\_\_\_\_\_  
Date