



Center For Cosmetic & General Dentistry

## Welcome to our practice.

Please take a few moments to complete *both* sides of this form. If you have any questions we'll be glad to help you.

### Patient Information

Email Address \_\_\_\_\_ Cell Phone Number \_\_\_\_\_  
 First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Sex: M F Age \_\_\_\_\_ Birthdate \_\_\_\_ \ \_\_\_\_ \ \_\_\_\_  
 Marital Status \_\_\_\_\_ Home Number \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Patient Employer \_\_\_\_\_ Work Number \_\_\_\_\_  
 In case of emergency please call: \_\_\_\_\_ Number \_\_\_\_\_  
 Is patient a student? If so, please list school and state: \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_

### Responsible Party/Insurance Information

Person Responsible for Account: First Name \_\_\_\_\_ Last \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_ Home Number \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Birthdate \_\_\_\_ \ \_\_\_\_ \ \_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Employer \_\_\_\_\_ Work Number \_\_\_\_\_  
 Name of Insurance Company \_\_\_\_\_

### Office Information

For your convenience, we accept cash, personal check, MasterCard, Visa and Discover Card. We also offer outside financing through **CareCredit**. If you would like more information, please ask someone at the front desk. 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 our policies are important parts of our professional relationship. Please ask us if you have any questions.

I have read and understand the above as described.

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

\*form continues on back

## Medical History

Physician's Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

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

Artificial Joints

Asthma

Cancer

Chemical Dependency

Diabetes

Epilepsy

Glaucoma

Heart Problems

- Artificial Valves
- Murmurs
- Mitral Value Prolapse
- Pacemaker

Hepatitis

High Blood Pressure

HIV/AIDS

Kidney Disease

Liver Disease

Prolonged Bleeding

Radiation Treatment

Respiratory Disease

Rheumatic Fever

Shortness of Breath

Skin Rash or Hives

Stroke

Swelling of Feet or Ankles

Thyroid Problems

Tobacco Habit

Tuberculosis

Venereal Disease

List any medications that you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

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

Aspirin

Codeine

Erythromycin

Latex

Local Anesthetic

Nitrous Oxide

Penicillin

Sulfa Drugs

Tetracycline

Other: \_\_\_\_\_

## 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

Bleeding gums

Clicking or popping jaw

Food collection between teeth

Grinding teeth

Loose teeth or broken fillings

Periodontal treatment

Sensitivity to cold

Sensitivity to hot

Sensitivity to sweets

Sensitivity when biting

Sores/growths in mouth

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

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:** If you have a balance on your account that is 45 or more days old, we will send you a monthly statement showing the account balance, any charges made to the account, and any payments if applicable. If you have insurance, you will be billed for the portions that you owe until the insurance has made their payment. 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:** Unless other arrangements have been approved by us, the balance on your statement is due and payable upon receipt, and is past due if not received by the due date.

**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.

**Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to your contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **You agree to pay any portion of the charges not covered by insurance.** We *do not* file pre-determinations. This again is only an estimate of what the insurance may pay, not a guarantee.

Sample: Insurance pays 100% of a procedure  
Our fee: \$5.00 Insurance RC fee: \$3.00 (reasonable & customary)  
Insurance will pay 100% of \$3.00, not our fee of \$5.00

**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. The FINANCE CHARGE will be computed at the rate of (1.8%) per month or an ANNUAL PERCENTAGE RATE of (21.6%). The finance charge on your account is computed by applying the periodic rate (1.8%) to the “overdue balance” of your account. The “overdue balance” of your account is calculated by taking the balance owed sixty (60) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is \$.50.

**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.

**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 \$25) for any checks returned by the bank.



**Appointment Confirmations:** Our office uses an automated service to confirm appointments via cell phone, email, pagers, and pda's. Since we send text you don't have to answer a call. Simply read it and respond at your convenience. Messages are sent 1 week prior to your scheduled appointment, 2 days prior to your appointment, and 1 hour prior on the day of the appointment. Please make sure we have current email addresses and cell phone numbers.

**Missed Appointment Fee:** The second time a patient fails to keep a scheduled appointment, or cancels 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 three failed appointments may be asked to transfer their records to another dental practice.

**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 not patient)

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

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### 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}

# NOTICE OF PRIVACY PRACTICES

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**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 INFORMATION IS IMPORTANT TO US.**

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## **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 this Notice about our privacy practices, our legal duties, and your rights concerning your health information.

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.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**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. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a 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 person 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 a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health 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, or 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 authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text 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 practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$5.00 for each page, \$15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Restriction:** 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 right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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.

Contact Officer: Dr. Jan C. Kraska

Address: 502 N. Elam Avenue, Greensboro NC 27403

Telephone: (336) 292-0863

Fax: (336) 292-2583

E-mail: kraskacenter@triad.rr.com