K.C. Sykora, DDS

FAMILY & IMPLANT DENTISTRY

Thank you for choosing our practice. Our mission is to help you help you have healthy teeth and gums by providing excellent care with exceptional service. Please fill out this form as completely as you can. If you have any questions, we'll be glad to help you. (Please print)

Name _____ [ ] Dr. [ ]Mr. [ ] Mrs. [ ] Rev. Other _____

Address _____ Occupation _____
First MI Last

City _____ State _____ Zip _____ Hm # (____) _____-_____

Employer _____ Wk# (____) _____-_____ Ext _____

Are you: [ ] Minor [ ] Married [ ] [ ] Single [ ]Divorced [ ] Widowed [ ] Separated Cell # (____) _____-_____

DOB (M/D/Y): ____/____/____ SSN _____ - _____ - _____ Email _____@ _____

Spouse's Name _____
First MI Last

Spouse's Occupation _____ Wk # (____) _____-_____ Ext _____

Is patient a full time student? [ ] No [ ] Yes If yes, name of school _____

Responsible Party (if different than patient) : Name _____
First MI Last

Address _____ City _____ State _____ Zip _____

Hm # (____) _____-_____ Wk # (____) _____-_____ Ext _____ Relationship to patient _____

DOB (M/D/Y): ____/____/____ SSN _____ - _____ - _____

Contact Preferences Do you prefer appointment reminders by [ ] Email [ ] Phone [ ] Text messaging

Do you prefer to receive calls from our office at: [ ] Home [ ] Cell [ ] Work

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Whom may we thank for referring you to us? _____

How do you wish to be addressed by our staff? _____

INSURANCE INFORMATION – MEDICAL INSURANCE

Subscriber's Name _____ Relationship to Patient _____

DOB (M/D/Y): ____/____/____ Subscriber SSN: _____ - _____ - _____

Insurance Company _____ Policy # _____ Group # _____

DENTAL INSURANCE

Insured's Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

DOB (M/D/Y): ____/____/____ SSN _____ - _____ - _____ Employer _____

Insurance Company _____ Policy # _____ Eff. Date ____/____/_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, Please complete the following:

Insured's Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

DOB (M/D/Y): ____/____/____ SSN _____ - _____ - _____ Employer _____

Insurance Company _____ Group # _____ Eff. Date ____/____/_____

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MEDICAL HISTORY and CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Allergies

Acrylics	Y	N
Anaphalaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

List other known allergies:

_____

_____

_____

_____

_____

Cardiovascular

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Change	Y	N
Thyroid problems	Y	N

Eyes, Ears, Nose and Throat

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus	Y	N

Gastrointestinal

Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

Genitourinary

Frequent Urination	Y	N
Kidney disease	Y	N
Nocturia	Y	N

General

Current weight: _____ lbs

Height: _____ ft _____ in

Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/hip replacement	Y	N
Liver problems	Y	N
Recent Trauma or Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Weight Change	Y	N

Hematological

Bleeding problems	Y	N
Hepatitis	Y	N

Oral

Bleeding gums	Y	N
Dry mouth	Y	N
Jaw problems (TMJ)?	Y	N
Clicking?	Y	N
Pain?	Y	N
Difficulty swallowing?	Y	N
Difficulty chewing?	Y	N
Orthodontics/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth clenching	Y	N
Teeth grinding	Y	N
Tooth pain	Y	N
Wisdom teeth extraction	Y	N
Do you wear removable teeth?	Y	N
Do you take or need antibiotics before dental procedures?	Y	N

Musculoskeletal

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N

Neurological

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating disorders	Y	N
Excessive Stress	Y	N
Memory problems	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Breathing problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Dyspnea(shortness of breath)	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

Sleep

Daytime Sleepiness	Y	N
Morning headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N

How often? _____

Has anyone told you that you snore?	Y	N

Social History

Do you smoke? N Y

_____ packs a day

Do you use smokeless tobacco? Y N

Do you consume alcoholic beverages?

_____Drinks per day/week/month

Do you use recreational drugs? Y N

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MEDICAL HISTORY and CONSENT

List any medications you are taking:

Medication	Dosage/Frequency	Prescriber	Reason

List any surgeries or hospitalizations you have had:

Date (year)	Surgery	Surgeon	Reason

List any medical condition not listed above:

_____

_____

_____

_____

Primary Physician's name: _____ Physician's phone # _____

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: I/the undersigned, hereby aurhorizes K. C. Sykora DDS. To take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize K. C. Sykora DDS, to perform any and all forms of treatment, meciation, and therapy that may be necessary and further consent that K. C. Sykora DDS, choose and employ such assistance as deemed necessary. I understand that the use of local anesthetic agents embodies certain risk and consent to their use as deemed appropriate by K. C. Sykora DDS. To the best of my knowledge, the questions on this 3 page form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medication, health, status, or insurance coverage.

FINANCIAL CONSENT: I understand that the responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am fully responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I acknowledge that I am responsible for all fees necessary to collect my account. I authorize K. C. Sykora DDS, and his staff to verify insurance coverage, if any, to submit claims and to provide my insurance company with information required of a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (adult):

Name of Patient _____ Signature of Patient _____ Date _____

Consent (for a minor child):

Name of Parent/Guardian _____ Signature of Parent/Guardian _____ Date _____

Notice of Privacy Practices (below)

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving and reading notice of our practice's policies and your rights regarding PHI. I allow release of pertinent medical and dental records to my insurance company (if applicable) and to my other medical providers, as Dr. Sykora may deem necessary. Signature of Patient _____ Date _____

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K. C. Sykora DDS

Financial Guidelines and Responsibilities

Thank you for choosing our office for your dental needs. Financial considerations should not be an obstacle to obtaining this important life-enhancing care. We want to assist you in any way we can.

Payment Options: In addition to accepting cash, personal checks and credit cards, we also provide the following payment options for your convenience;

1. **Estimated Insurance Co-Payment at time of service**
2. **Monthly Payment Plans**
    a. Interest-Free Credit Line with monthly payments for a period of up to twelve months, for qualifying individuals- with outside vendors.
    b. "Lay-Away" Plan: treatment begins after comfortable monthly payments have been made which add up to the total of the estimated fees.
3. **Discount for Payment in Full prior to commencing treatment for patients without insurance.** For all services above $500, a bookkeeping courtesy discount of 5% will be given for payment in full by cash or check prior to beginning treatment. Alternatively, a 3% discount will be given for credit card payment in full prior to beginning treatment.

Financial Responsibilities

I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered that is not covered by my medical or dental insurance.

The practice will provide a best-estimate of coverage and costs, but I understand that this **IS NOT** a guarantee of payment. Until we receive the actual payment from the insurance company, it is just that, an estimate. I understand that I am responsible for any charges that may exceed my maximum yearly benefit. I also understand that if I have seen another dentist who has received dental benefits from my insurance company, it is my obligation to notify this office in order for the remaining benefits to be calculated accurately.

I understand that most policies do not cover 100% of the cost of treatment. Due to the usual extreme delay in claim processing, if after 45 days, the insurance company has not paid the claim, the balance will be due and payable in full by me, and that any future insurance payment will be promptly refunded to me

I authorize K. C. Sykora, DDS and his staff to verify insurance coverage, submit claims and provide my insurance company with information required to submit claims, assign benefits, and to handle any necessary claims appeals.

I _____ certify that I have read and understood this document and that I (the patient or responsible party) accept the above financial guidelines and responsibilities. Date:_____