DEAN J. KOKINIAS, D.D.S.

Patient Registration and Health History

Patient Information *(all information will be kept strictly confidential)*

Name _____ **Gender** ☐ **M** ☐ **F** **Birthdate** _____/____/_____
Street Address _____ **City** _____ **State** _____ **Zip** _____
Email Address: _____ **Cell Phone** _____ **Patient SSN** _____/____/_____
Check Appropriate Box: ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**
Name of person responsible for your account: _____ ☐**Self** ☐**Mother** ☐ **Father** ☐**Guardian**
Insured's name: _____ **Insured's SSN** _____/_____/_____ **Insured's DOB** ___/___/____
Emergency Contact _____ **Cell Phone** _____ **Relationship** _____
Referred by? (Name) _____ ☐**Relative** ☐**Friend** ☐**Co-worker** ☐**Google**

Dental History

Date of last Dental checkup and cleaning _____

Do you have or have you had any of the following, please indicate with a (✓)

☐ **Teeth sensitive to cold, heat, sweets, or pressure**	☐ **Pain around ear**	☐ **Burning of tongue**
☐ **Bleeding gums**	☐ **Clicking or popping of jaw**	☐ **Bad Breath**
☐ **Teeth clenching or grinding**	☐ **Unfavorable dental experience**	☐ **Unpleasant taste**
☐ **Complications from extractions**	☐ **Frequent blisters on lips or in mouth**	☐ **Wisdom tooth pain**
☐ **Swelling or lumps in mouth**	☐ **Orthodontic Treatment**	

I would like to discuss? ☐ **Enhancing my smile** ☐ **Whitening my teeth** ☐ **Orthodontics (Invisalign)**

Have you ever been diagnosed with Sleep Apnea? ☐**YES** ☐**NO** **Sleep study performed?** ☐**YES** ☐**NO**

Medical History

Physician's Name _____ **Office Phone** _____ **Date of last physical exam** _____

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

Aspirin Penicillin Codeine Sulfa Acrylics Metals Latex Local Anesthetics

Other Allergies: _____

Do you have or have you had any of the following, please indicate with a (✓)

☐ **Radiation treatments**	☐ **Hepatitis or liver disease**	☐ **Epilepsy**
☐ **Excessive bleeding from cut or extraction**	☐ **Cancer**	☐ **Rheumatic Fever**
☐ **High blood pressure** ☐ **Low blood pressure**	☐ **Anemia or blood problems**	☐ **Sinus problems**
☐ **Heart Murmur**	☐ **Arthritis**	☐ **Respiratory Disease**
☐ **Mitral Valve Prolapsed**	☐ **Asthma**	☐ **Stroke**
☐ **Artificial heart valves or joints**	☐ **Hay fever or allergies in general**	☐ **Tuberculosis**
☐ **Any other heart ailments**	☐ **Diabetes**	☐ **Herpes venereal disease**
☐ **Neurological problems**	☐ **Kidney problems**	☐ **HIV Positive**
☐ **Ulcer or Colitis**	☐ **Thyroid Disorder**	☐ **A.I.D.S**

Do you require pre-medication for your dental visits? ☐ **YES** ☐ **NO** ☐ **I don't know**
List any medications you are currently taking or attach list? _____
Are you currently under the care of a physician? ☐ **YES** ☐ **NO** **For what condition?** _____
(Women only) Are you pregnant? ☐**Yes** ☐**No** **Nursing?** ☐**Yes** ☐**No** **Taking birth control pills?** ☐**Yes** ☐**No**
Is there anything else we should know about your medical history? _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous for my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist all insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature, Parent or Guardian _____ **Date** _____

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FINANCIAL AND OFFICE POLICIES

Thank you for choosing Dr. Kokinias for your dental needs. This document will provide you with information to better understand your obligations as a patient or person responsible for this patient's account. Please review and sign. We look forward to seeing you on a regular basis.

CANCELLATION AND NO-SHOW POLICY

Office hours are by appointment. Appointment time is reserved for you alone and we respect your time. We work very hard to accommodate the needs of all our patients. Therefore, when you make an appointment, please be sure that you will be able to keep it. If you must cancel or reschedule an appointment, please notify the office during regular business hours Mon-Fri at least 24 hours prior to your appointment time. Messages left after business hours for next day appointments will be considered broken. There will be a minimum charge of $50 plus $25 additional for each half hour after first 60 minutes for a broken appointment or cancellation with less than 24-hour notice of your appointment time. Your insurance does not cover this charge. Of course, we understand that emergencies can arise, and we will take those into consideration. Continued disregard of this policy may result in dismissal from our practice. We can answer any questions you may have about our appointment late cancellation and no-show policy.

FINANCIAL POLICY

Payment for treatment is required at the time of service. If you have insurance benefits, as a courtesy to you, we will submit your insurance claims for you based on the information you provide. Your deductible and any copayment amount are due at the time of service. Insurance is not always a guarantee of payment, and you are ultimately responsible for payment of your account. Some insurance carriers may require you to pay us at the time of service and receive reimbursement directly from them. Financing is available through CareCredit. Please ask our receptionist for more information. In the event your payments are not received by the due dates, a fee of 18% APR will be added to your account, minimum fee is $10. Returned checks will incur a $25 service fee. After 90 days, outstanding balances are turned over to our collection agency where you will be responsible for all costs of collection, including collection agency fees, attorney fees and court costs. You will also be dismissed from our practice.

PATIENT COMMUNICATION

We may call your home, cell or other designated location and leave a message on voice mail or with any person who answers, send emails or text messages regarding any items that assist the practice in carrying out treatment, payment and other operations, such as appointment reminders, insurance items and any call pertaining to your dental care, including treatment planning.

I have read and agree to the cancellation and no-show policy, office communication and financial policies.

_____	_____	_____
Patient Signature (parent, if minor)	Print Patient Name	Date