

# Kravanya & Boente Family Dentistry

204 Oakland Ave. • Carlinville, IL 62626

(217)854-4741

## Welcome to our Practice

Chart#: \_\_\_\_\_  
FOR OFFICE USE ONLY

Patient Name: \_\_\_\_\_

Title: \_\_\_\_\_ Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc Last First MI Preferred Name

Birth Date: \_\_\_\_\_ Prev. Visit: \_\_\_\_\_ Email Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Home Mobile Work Ext

Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

## Employment Information

The following is for:  the patient  the person responsible for payment  both  not applicable

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number:

## Responsible Party/Insurance Information

Person responsible for this account:

Self  Other

If other, name, birthdate, and relationship of person responsible:

Primary Dental Insurance:

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Address 1 Address 2

City

State

Zip Code

Insured's Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Address 1

Address 2

City

State

Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Address 1

Address 2

City

State

Zip Code

Policy Holder's SSN: \_\_\_\_\_

**Secondary Dental Insurance**

Name of insured: \_\_\_\_\_

Last

First

MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Address 1

Address 2

City

State

Zip Code

Insured's Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Address 1

Address 2

City

State

Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Address 1

Address 2

City

State

Zip Code

Policy Holder's SSN: \_\_\_\_\_

**Insurance Authorization:**

- By checking this box,
  - I authorize my insurance company to pay the dentist all insurance benefits rendered.
  - I authorize the use of this electronic signature on all insurance submissions.
  - I authorize the dentist to release all information necessary to secure the payment of benefits.
  - I understand that I am financially responsible for all charges whether or not paid by insurance.

### Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> *Aspirin Allergy     | <input type="checkbox"/> *Augmentin Allergy  | <input type="checkbox"/> *Codeine Allergy     | <input type="checkbox"/> *Erythro Allergy     |
| <input type="checkbox"/> *Fluoride Allergy    | <input type="checkbox"/> *Latex Allergy      | <input type="checkbox"/> *Neomycin Allergy    | <input type="checkbox"/> *Novacaine allergy   |
| <input type="checkbox"/> *Penicillin Allergy  | <input type="checkbox"/> *Septra Allergy     | <input type="checkbox"/> *Sulfa Allergy       | <input type="checkbox"/> *Tylenol Allergy     |
| <input type="checkbox"/> *Valium Allergy      | <input type="checkbox"/> *Zithromax Allergy  | <input type="checkbox"/> Allergies            | <input type="checkbox"/> Anemia               |
| <input type="checkbox"/> Art. Heart Valve     | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Blood Disease        | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Currently Pregnant   | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Excessive Bleeding   | <input type="checkbox"/> Fainting             |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Growths             | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Head Injuries        |
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Hip replacement      | <input type="checkbox"/> Histoplasmosis      | <input type="checkbox"/> HIV                  | <input type="checkbox"/> Iodine               |
| <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Kidney Donor         | <input type="checkbox"/> Knee Replacement     |
| <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Mentally handicapped |
| <input type="checkbox"/> Mitral Value Prolaps | <input type="checkbox"/> Nervous Disorders   | <input type="checkbox"/> Other                | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> Premedicate          | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> Sinus Problems      | <input type="checkbox"/> Stomach Problems     | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Tumors              | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Venereal Disease     |

- |   |  |
|---|--|
| <input type="checkbox"/> Ever been hospitalized (illness or injury)         | <input type="checkbox"/> Presently being treated for any other illnesses |
| <input type="checkbox"/> Taking medication for weight control (ie fen-phen) | <input type="checkbox"/> Taking dietary supplements                      |
| <input type="checkbox"/> Subject to frequent headaches                      | <input type="checkbox"/> A smoker or smoked previously                   |
| <input type="checkbox"/> FEMALE: Taking birth control pills                 | <input type="checkbox"/> FEMALE: Pregnant                                |

Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates?  Yes  No

If yes, please include the date the medication was started and the date of the last dose:

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If you have had any artificial joint or heart valve surgery please indicate the date the surgery was performed:

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If any conditions or alerts selected above needs further clarification, please describe below:

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Do you take antibiotic premedication for your dental visits?  Yes  No

Name of physician and their specialty:

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Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

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List all medications, supplements, and/or vitamins taken within the last two years:

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\* By checking this box, I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

**Dental Information**

Date of most recent dental exam: \_\_\_\_\_

I routinely see my dentist every:

- 3 mo.     4 mo.     6 mo.     12 mo.     Not routinely

What is your immediate concern?

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Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) \_\_\_\_\_

**Consent for Services and Financial Policy**

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/4% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of 6 months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within thirty (30) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

\* By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.

## HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

\*By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

## Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

\*I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Name of Patient, Parent or Guardian completing this Form \*

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Response Date: \_\_\_/\_\_\_/\_\_\_