BOZENTKA
ORAL & MAXILLOFACIAL SURGERY
WISDOM TEETH & DENTAL IMPLANTS

Patient Information

Please fill in the following form to the best of your ability. The contents of this form are private and will be maintained as described in the HIPAA Consent form.

1. Patient Details

First Name: | Middle Name: | Last Name: | Title: | Nickname:

SSN: | Birthdate: | Gender: | Email Address:

Patient Height | Patient Weight

Home Address

Street Address: | Apt./Unit #: | City: | State: | Zip Code:

Phone Number(s) (At least one phone number is required)

Home Phone: | Cell Phone: | Work Phone: | Ext.:

Emergency Contact

2. Emergency Contact Details

Emergency Contact First Name: | Emergency Contact Last Name: | Emergency Contact Relationship to Patient:

Phone Number(s) (At least one phone number is required)

3. Who is your referring doctor?

4. Pharmacy name, telephone # and location (include zip code)

Responsible Party (Person who holds insurance policy)

5. **Responsible Party Details**

Responsible Party First Name:

Middle Name:

Responsible Party Last Name:

Responsible Party Relationship to Patient

Responsible Party SSN:

Responsible Party Birth Date:

Responsible Party Gender:

Responsible Party Email:

Home Address

Responsible Party Street Address:

Address Line 2:

Responsible Party City:

Responsible Party State:

Responsible Party Zip Code:

Phone Number(s) (At least one phone number is required)

Responsible Party Phone:

Responsible Party Home Phone Number:

Responsible Party Work Phone Number:

Ext.:

6. **Please add images or PDF of both front and back of your drivers license or state ID if you are over the age of 18. If you are under the age of 18, please have your parent or guardian whom is the policy holder for your insurance do so.**

Medical Insurance

7. **If you do not have medical insurance, or have traditional medicare please select self pay. We do NOT participate with any state funded insurances.**

Policy Holder's Name

Policy Holder's Birthdate:

Insurance Policy #

Patient's Relationship to Policy Holder:

Plan/Policy

Primary Insurance Plan

Secondary Insurance Plan

Group Number:

Address Line 1:

Address Line 2:

City:

State:

ZIP:

8. Please add images or PDF of both front and back of your medical insurance card.

Dental Insurance

9. If you do not have dental insurance, please select self pay.

Policy Holder's Name

Policy Holder's Birthdate:

Insurance Policy #

Patient's Relationship to Policy Holder:

Plan/Policy

Primary Dental Insurance Plan

Secondary Dental Insurance Plan

Group Number:

Address Line 1:

Address Line 2:

City:

State:

ZIP:

10. Please add images or PDF of both front and back of your dental insurance card.

Medical Health History

11. Allergies: Are you allergic to or have you had reaction to:

- ☐ Aspirin
- ☐ Barbituates or sedatives
- ☐ Certain foods
- ☐ Codeine
- ☐ General anesthetics
- ☐ Hay fever/seasonal
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetics
- ☐ None
- ☐ Other Antibiotics
- ☐ Other Narcotics
- ☐ Penicillin
- ☐ Sleeping pills
- ☐ Sulfa drugs

Other:

12. Medications: Please list any and all medications you are on. If you have a list of medications, feel free to attach the list at the section below.

Other:

13. Please add images or PDF of your medication list if you have one.

14. Have you had any surgeries? If so, please list them below

15. Is there any other health item we should be aware of (Medical Alert)?

16. Are you on any blood thinners (Plavix, Eliquis, Brilinta, Xarelto... or any osteoporosis medication?

17. Medical Conditions: Do you have, or have you had any of the following?

- ☐ Abnormal bleeding
- ☐ Alcohol abuse
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artitificial heart
- ☐ Artitificial joints
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer/chemotherapy
- ☐ Colitis
- ☐ Congenital heart defect
- ☐ Diabetes
- ☐ Difficulty breathing
- ☐ Drug abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Fever blisters
- ☐ Frequent headaches
- ☐ Glaucoma
- ☐ HIV or AIDS
- ☐ Heart attack
- ☐ Heart surgery
- ☐ Hemophilia
- ☐ Hepatitis A or B
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Mitral valve
- ☐ None
- ☐ Pace maker
- ☐ Pneumocystis
- ☐ Psychiatric problems
- ☐ Radiation therapy
- ☐ Rheumatic fever
- ☐ Shingles
- ☐ Sickle cell disease
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Organ transplant
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Yellow jaundice

Other:

18. Other Health

- ☐ Do you use tobacco?
- ☐ Do you use controlled substances (drugs)?
- ☐ Are you required to premedicate before any dental treatment?

19. WOMEN ONLY:

☐ Are you pregnant? Number of weeks: _____ ☐ Are you nursing?

Misc.

20. Do you have a POA (Power of Attorney)?

_____

21. Please remember your X-RAY's and referral for your appointment. If you do not have these, please call your dentist and request them to be sent to us at info@nbozentka.com.
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PRACTICE PATIENT RESPONSIBLITY AGREEMENT

I understand and agree that I will be financially responsible for the patient services provided by the DENTAL OFFICE OF NEAL E. BOZENTKA, DMD, PC (also called the "Dental Office"), according to the policies stated in this Patient Responsibility Agreement.

TREATMENT PLAN. I acknowledge that I am financially responsible for all patient services, including services, which may or itemized in the treatment plan or as amended from time to time.

PATIENT INFORMATION. The patient information provided to the Dental Office is true and correct. I will notify the Dental Office about any significant future revisions to the patient information furnished.

INSURANCE. If I expect my insurer to cover some or all of the cost of the patient services, the Dental Office will assist me, as a courtesy, in obtaining the appropriate benefits from the insurer by billing the insurer. I agree to cooperate and provide all information necessary to the Dental Office. However, I have the primary relationship with my insurer and the Dental Office is not responsible for guaranteeing that benefits will be received in the amounts and in the time-frame as requested. I am responsible to resolve any problems with my insurer. I may request that the Dental Office obtain a pre-estimate of insurance benefits before patient services are performed.

BILLING STATEMENT. It is possible that portions of the bill for patient services, such as co-payments, deductibles and exclusions, may not be paid by the insurer. Those unpaid portions must be paid by me at the time the patient services are performed. Payments may be made in cash, check, or by credit card. **All credit card payments will incur a fee of 3%, any payments made using cash, check, HSA, FSA or debit card do NOT incur any fees. We do NOT accept Care Credit.**

REFERRAL FOR COLLECTION. If my account is referred to an outside agency or attorney for collection after 90 days, I will also be responsible for actual collection costs incurred, including all attorney's fees and court costs. The Dental Office may deny subsequent patient treatment if my account balance remains unpaid.

ACCOUNT CHARGES. If my account remains unpaid after 90 days, I can be assessed with additional charges at the rate of 1-1/2% per month (18% annually).

ACCOUNT ADJUSTMENT. If I fail to make a co-payment by the date required by my insurer, if applicable, then my account can be adjusted and I would be responsible for the full amount due for the patient services rendered.

FAMILY RESPONSIBILITY. I am authorized to agree, for myself and on behalf of my spouse (if applicable), to remain financially responsible for all future services rendered to all of my family members, regardless of age, unless I notify the Dental Office in writing otherwise.

COLLECTION FROM OTHERS. If I am financially indigent and unable to pay for patient services rendered, the Dental Office may seek to recover my account balance from certain of my adult relatives under applicable Pennsylvania law.

CANCELLED APPOINTMENTS. If an office appointment in cancelled with less than 24 hours notice, I will be assessed with a cancellation charge of $50.00 for a Biopsy appointment. $100.00 for an Impaction appointment and $200.00 for an Implant appointment. For continuous cancellation of appointments the patient will need to give a $50.00 deposit before an appointment is rescheduled.

RETURNED CHECKS. If my check is returned by the bank, I can be assessed with a processing charge of $20.00.

22. May we leave a recorded message regarding your financial responsibilities on your home and/or cell phone?

○ Yes ○ No

By signing this, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A detailed description of the HIPAA policy is attached for your review and signature.

_____ _____

Signature Date