JAMES A. OSHETSKI, DDS

IMPLANT AND RESTORATIVE DENTISTRY

PATIENT INFORMATION

Patient Name	Prefix (circle one): Mr. / Mrs. / Ms.	Preferred Name
Date of Birth	Social Security #	Marital Status
Mailing Address		
City	State	Zip

CONTACT INFORMATION

Please check your preferred contact number

☐ Home	☐ Cell	☐ Work
Employer	Email address	

REFERRAL INFORMATION

☐ Website/Internet	☐ Dentist/Doctor	☐ Work in building	☐ Existing patient

If referred by a patient, please provide their name so that we may thank them:

IN CASE OF AN EMERGENCY

Please provide the name of a local friend or relative

Emergency Contact Name	Relationship to patient
Home Phone	Cell Phone

INSURANCE INFORMATION

Please give your insurance card to the receptionist

Name of primary dental insurance company		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security #
Group Name	Group #	Subscriber Id#

Patient's relationship to Subscriber Self Spouse Child Other

Name of Secondary dental insurance company (If Applicable)		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security #
Group Name	Group #	Subscriber Id#

Patient's relationship to Subscriber Self Spouse Child Other

NOTE TO PATIENTS WITH INSURANCE: We are happy to process any insurance claim as a service to you at no charge. We are proud that our fees reflect the time that the doctor spends with each patient as well as the overall quality of care and service that we provide in our practice. Our fees are not based upon any insurance schedules or allowances. Please be aware that your insurance policy is a contract between you and the insurance company. Also, please keep in mind that any estimate we provide to you is only an estimate and that you are responsible for all fees in their entirety at the time of your visit.

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CONSENT FOR SERVICE & PAYMENT

I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorize. Despite the most diligent care and precaution, unanticipated complications or unintended results, although rare, may occur. A treatment plan is based on the best evidence available during the examination. There is no guarantee that this plan will not change. During treatment, it may be necessary to change or add procedures because of conditions that were not evident during examination but were found during the course of treatment. Any changes in treatment plan may result in additional fees.

Treatment Recommendations are based on information gained from diagnostic procedures and examination and may vary for similar situations. The goal of treatment is to assist you in attaining optimum dental health and appearance. We will discuss with you the most appropriate and ideal treatment plan as well as reasonable alternative treatment plans. We will also inform you of the likely dental prognosis for each of these treatment plans and dental prognosis if no treatment is initiated at this time.

Upon such diagnosis, I authorize Dr. Oshetski or the designated staff person to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I authorize any necessary care and treatment such as: examination, laboratory testing and or procedures, administration of local anesthetics, medication and treatment as directed by my dentist or treating practitioner. I acknowledge that no guarantees have been made to me as to the effort of such examinations, tests, procedures or treatment of my condition.

By providing contact information I consent to have you, or staff members contact me regarding appointments through U.S. Mail, text, e-mail, and or voice messages at home or at work.

I consent to photography, video recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I authorize the release of any information related to dental claims.

I understand that I am responsible for knowing the terms and conditions of my insurance coverage. I further understand that I may be responsible for obtaining prior authorization for certain procedures in order for my insurance company to pay for those services. I understand that I am personally responsible for payment and it is my responsibility to ensure that reimbursement is received from my insurance company. As a courtesy James A. Oshetski, DDS will accept payment directly from your insurance company, however ultimately your account and any unpaid balance is the patient's responsibility.

In consideration for services rendered by James A. Oshetski, DDS, I guarantee prompt payment for services at the time they are provided. I am aware that because of direct billing to my insurance company, I will be asked to pay my estimated portion on the date of service. Any unpaid balances will be billed upon receipt of insurance. Payment must be received within 30 (thirty) days from the receipt of statement. If unpaid for 90 days, a first attempt to contact me will be made via phone or email. If unsuccessful I will receive a final attempt to collect a debt letter. After 30 days if my account remains unpaid my balance will be sent to a collection's agency and if so, I agree to pay all reasonable costs including attorney's fees and/or collection fees in addition. Once mt account is sent to a collection agency my patient-doctor relationship is terminated. If I have other family members on my account, the balances for each responsible party will be sent separately.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

_____ _____

Print Patient Name Signature of Patient, Parent or Guardian

_____ _____

Relationship to patient Date

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APPOINTMENT CANCELATION POLICY

Initials: _____ When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advanced notice of 24 business hours**. We understand that conflicts arise; however failing your appointment or canceling without adequate notice more than once will result in a $100 per hour charge for a Hygienist appointment, a $200 per hour charge for a general appointment with Dr. Oshetski, and a $500 charge for surgical appointments and may result of discontinuation of service.

HEALTH CARE INSURANCE PORTIBILITY & ACCOUNTABILITY ACT

Acknowledgement of Receipt of Notice of Privacy Practices

***You may refuse to sign this Acknowledgement**

I a copy of this office's Privacy Practices has been provided on request regarding healthcare information as required by Federal Regulation. Alternatively, I have also been informed that there is a copy posted for viewing in the reception area.

_____ Print Patient Name

_____ Signature of Patient, Parent or Guardian

_____ Relationship to patient

_____ Date

For Office Use Only

We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication Barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (please specify):

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DENTAL HISTORY

Patient Name: Date:

What is the main purpose of your visit today?

When was your last dental visit?

Does dental treatment make you nervous?

☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Have you ever had the following for dental treatment?

☐ Nitrous Oxide (Laughing gas) ☐ Intravenous sedation ☐ Oral sedation

Are you concerned about or experiencing any of the following dental problems? (Please check all that apply)

☐ Discoloration of teeth	☐ Tooth cleaning techniques	☐ Silver fillings
☐ Bleeding gums	☐ Roughness of existing fillings	☐ Clicking/pain in the jaw
☐ Your smile	☐ Missing teeth	☐ Grinding of teeth
☐ Bad breath	☐ Food trapped between teeth	☐ Head/neck ache
☐ Previous dental visits	☐ Sensitivity to hot or cold	☐ Existing crowns, implants, or dentures

MEDICAL HISTORY

Name of your Primary Care Physician/Practice Name	Preferred Pharmacy

Have you ever had any of the following? (Please check all that apply)

☐ Heart Disease	☐ Excessive Bleeding	☐ COPD
☐ Rheumatic Fever	☐ Diabetes (A1C) _____	☐ Asthma
☐ Heart Attack (When) _____	☐ Thyroid Disease	☐ Tuberculosis
☐ Stroke (When) _____	☐ Acid Reflux	☐ Cancer
☐ Arrhythmia	☐ Hepatitis A, B, or C	☐ Tumors
☐ Congenital Heart Defect	☐ HIV/AIDS	☐ Bisphosphonates
☐ Angina/Chest Pain	☐ Liver Disease	☐ Radiation/ chemotherapy
☐ High Blood Pressure	☐ Kidney Disease	☐ Artificial Joints (When)_____
☐ Pacemaker	☐ Glaucoma	☐ Epilepsy/Seizures
☐ Fainting/ Dizziness	☐ Sleep Apnea	☐ Alzheimer's Disease
☐ Anemia	☐ Sinus Problems	☐ Psychological Disorders

Do you or have you ever taken oral or IV Bisphosphonates for osteoporosis or chemotherapy?(i.e. Boniva, Fosamax, Zometa, Aredia, or Didronel)

☐ Yes (If yes, Name of Medication(s) how long?) ☐ No

Have you had ANY serious illness or surgery in the last 2 years?

☐ Yes (If yes, please explain) ☐ No

Do you use ANY of the following? TOBACCO MARIJUANA VAPE PEN

Do you drink alcohol?

☐ Yes (If yes, how many much and how often?) ☐ No

Are you pregnant?

☐ Yes (How many weeks?) ☐ No

Please list any MEDICATIONS & SUPPLEMENTS you are taking as well as dosage and reason for taking.

Please list all allergies to any medications.

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TMJ (Temporomandibular Joint) Health Questionnaire

Please check all that apply

- ☐ Pain in Jaw
  - ○ Right
  - ○ Left
- ☐ Pain While Chewing Gum
- ☐ Pain Chewing a Bagel
- ☐ Noise in Jaw Joint
- ☐ Can Make Jaw Pop or Crack
- ☐ Tired Jaw After a Big Meal
- ☐ Avoid Eating Certain Foods
- ☐ Difficulty Opening Wide
- ☐ Difficulty Yawning
- ☐ Dizziness
- ☐ Feel Faint
- ☐ Nausea
- ☐ Jaw Aches When Opening Wide
- ☐ Allergies
- ☐ Pain in Eyes
- ☐ Hearing Loss
- ☐ Itchiness or Stuffiness in Ear(s)
- ☐ Ringing, Buzzing, Hissing in Ear(s)
- ☐ Sinus Trouble

- ☐ Headaches
  - ○ Right Temple Area
  - ○ Left Temple Area
  - ○ Front of Head
  - ○ Back of Head
- ☐ Migraines
- ☐ Neck Pain
- ☐ Stiff Neck Muscles
- ☐ Chronic Shoulder or Back Pain
- ☐ Clench Teeth
  - ○ Day
  - ○ Night
- ☐ Grind Teeth During Sleep
- ☐ Trouble Sleeping Soundly
- ☐ Sore Teeth When You Wake
- ☐ Sore Jaw When You Wake
- ☐ Wisdom Teeth Removed
- ☐ Pain in around, behind either eye
- ☐ Blurred vision at times
- ☐ Snore
- ☐ Sleep Apnea
- ☐ Sleep Study Completed

Please describe your chief TMJ concern(s):

_____

_____

_____

When did the symptoms begin? _____

Do you take any medications for pain management? _____

If yes, what do you take and how often do you take it?

_____

Does anything make you feel better? _____

Patient Name: _____ **Date:** _____