BLASEK
FAMILY DENTISTRY

Patient Registration

Name: **Today's Date:**

Preferred Name:

Address: _____

City: _____ State/ Zip: _____

Primary Phone Number: _____

Secondary Number: _____

Sex: ☐ Male ☐ Female

Birth Date: _____ Age: _____ SSN: _____

Email: _____

INSURANCE:

☐ **I DO NOT HAVE DENTAL INSURANCE**

Primary Dental Insurance

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Insured SSN: _____ Member ID: _____

Employer/ Group Name: _____ Group Number: _____

Secondary Dental Insurance (if any)

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Insured SSN: _____ Member ID: _____

Employer/ Group Name: _____ Group Number: _____

Signature: _____ **Date:** _____

Blasek Family Dentistry

Health History Form

Name: **Today's Date:**

Are you under the care of a specialist? ☐ YES ☐ NO Physician Name Phone Number

Dental Information

1. Do your gums bleed when you brush or floss? ☐ YES ☐ NO
2. Are your teeth sensitive to cold, hot, sweets or pressure? ☐ YES ☐ NO
3. Is your mouth dry? ☐ YES ☐ NO
4. Have you ever had orthodontic (braces) treatment? ☐ YES ☐ NO
5. Have you had any problems associated with previous dental treatment? ☐ YES ☐ NO
6. Are you currently experiencing dental pain or discomfort? ☐ YES ☐ NO
7. Do you have earaches or neck pains? ☐ YES ☐ NO
8. Do you have any clicking, popping or discomfort in the jaw? ☐ YES ☐ NO
9. Do you grind your teeth? ☐ YES ☐ NO
10. Do you have sores or ulcers in your mouth? ☐ YES ☐ NO
11. Do you wear dentures or partials? ☐ YES ☐ NO
12. Have you ever had a serious injury to your head or mouth? ☐ YES ☐ NO

FOR NEW PATIENTS ONLY:

Date of your last dental exam: _____

What was done at that time? _____

Date of last dental x-rays: _____

Please list any medications, pills or drugs

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical Information

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Please list any other allergies

- Do you use tobacco? ☐ YES ☐ NO
- Do you use controlled substances? ☐ YES ☐ NO
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ YES ☐ NO If yes, please list

Women Only: Are you...

☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Tasking Oral contraceptives

Please indicate if you have any of the following

☐ Acid Reflux	☐ HIV +/AIDS	☐ Alzheimer's Disease	☐ Anaphlaxis	☐ Anemia
☐ Angina/ Chest Pain	☐ Arthritis/ Rheumatism	☐ Artificial Heart Valve	☐ Artificial Joint	☐ Asthma
☐ Blood Disease	☐ Blood Transfusion	☐ Bruise Easily	☐ Cancer IF YES, WHAT KIND?	☐ Chemotherapy
☐ Congenital Heart Disorder	☐ Convulsions	☐ COPD/ Lung Disease	☐ Diabetes (Type I/ Type II) PLEASE CIRCLE	☐ Drug Addiction
☐ Emphysema	☐ Epilepsy or Seizures	☐ Fainting Spells/ Dizziness	☐ Frequent Cough	☐ Frequent Headaches
☐ Glaucoma	☐ Heart attack/ Failure	☐ Heart Murmer	☐ Heart Pace Maker	☐ Heart Disease
☐ Hemophilia	☐ Hepatitis A/B/C PLEASE CIRCLE	☐ Herpes Type I/ Type II	☐ High Blood Pressure	☐ High Cholesterol
☐ Hives or Rash	☐ Hypoglycemia	☐ Kidney Problems	☐ Osteoporosis	☐ Parathyroid Disease
☐ Psychiatric Care	☐ Sickle Cell Disease	☐ Sinus Trouble	☐ Shingles	☐ Stroke
☐ Gout	☐ Sleep Apnea	☐ Tonsillitis	☐ Tuberculosis	☐ Taking- Anti-Coagulant
☐ Thyroid Disease	☐ Tumors or Growths	☐ Ulcers	☐ Venereal Disease	☐ Autoimmune Disease IF YES, WHAT KIND?

Have you ever had any serious illness not listed above?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____ **Date:** _____

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FINANCIAL POLICY

We are happy to have you as a patient and look forward to offering you the finest dental care available. We know that providing comprehensive dental services include discussing all the treatment thoroughly and financial information. It is our goal to make this process as easy and straight forward as possible.

Our goal is to assist you in maximizing your insurance benefits. Understanding your insurance can be challenging and each plan differs I its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

PAYMENT OPTIONS

- For patients that have dental insurance: your estimated portion of payment is due in full, before or at the time service is rendered. Patient is then responsible for the remaining balance after payment from insurance company is received.

- 5% discount on payments made in full prior to major treatment. (Only for patients that do not have dental insurance, the Dental Savings Plan, Senior Discount, or any other type of discount)

- Pay as you go: breaking up treatment into smaller phases and paying as each phase is complete.

- Care Credit: a healthcare credit card designed for your health and wellness needs. It's a way to pay for the costs of many treatments and procedures and allows you to make convenient monthly payments, interest free, if paid in 12 months or less.

ALL CROWNS CREATED BY BLASEK FAMILY DENTISTRY WILL BE GUARANTEED FOR 5 YEARS PROVIDED YOU COME TWO TIMES A YEAR FOR YOUR REGULAR HYGIENE VISITS.

All copays, deductibles, and estimated portions must be paid in full at the time of service. Our Doctors diagnose and treat each patient the same, regardless of insurance coverage. We do not allow insurance companies to dictate our treatment plans. If you have insurance, we are happy to provide you with an ESTIMATE of their portion, but we can never guarantee any insurance payments. **Your dental insurance is your responsibility, and it is in your hands to verify and confirm your benefits with your insurance company.** As a courtesy, we are happy to submit any claims for you. However, with the constant change of insurance company does not pay their portion, you are responsible for the payment of your treatment.

Signature of Patient

Date

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HIPAA PRIVACY AUTHORIZATION FORM

- I authorize Blasek Family Dentistry to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations quality reviews.

- I understand that Blasek Family Dentistry has the right to change their privacy practices and that I may obtain any revised notices at the practice.

- I understand I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restrictions, they must follow the restrictions.

- I understand that I have the right to revoke this authorization in writing at any time.

Signature: _____ Date: _____
Patient, parent, or legal guardian

Print Name: _____
Patient, parent, or legal guardian

If signed by a patient representative state relationship to patient: _____

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Welcome to our practice! We look forward to having you as a patient and thank you for choosing us for your dental care needs. To help us get to know you, please fill out this short questionnaire.

1. Who can we thank for referring you to our office?

- ○ Patient: _____
- ○ Specialist: _____
- ○ Facebook
- ○ Google
- ○ Insurance
- ○ Drive-by

2. Are you having any specific dental problems or concerns you want to discuss with the Dentist?

- ○ Discomfort and/or sensitivity
- ○ Straighter teeth
- ○ Brighter Smile
- ○ Interested in cosmetic work
- ○ Other _____

3. What is most important to you about your dental health?

4. What qualities are you looking for in a Dentist?

5. What is your preferred method of contact?

- ○ Phone
- ○ E-mail
- ○ Texting
- ○ All the above

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24-Hour Cancellation & No-Show Policy

At Blasek Family Dentistry, we strive to provide the highest level of care to our patients. To help ensure that we can accommodate all patients in a timely manner, we have implemented the following 24-hour cancellation and no-show policy:

Cancellations:
If you need to cancel or reschedule your appointment, please provide at least 24 hours' notice. This gives us time to offer the appointment slot to another patient in need of care.

No-Shows & Late Cancellations:
If you fail to show up for your appointment or cancel with less than 24 hours' notice, a $50 cancellation fee will be charged to your account.

Important Notes:

- In the event of a late cancellation or no-show, the fee is non-refundable and will be added to your next visit or charged to your credit card on file.
- We understand that emergencies happen. If you need to cancel due to an emergency, please let us know as soon as possible so we can work with you.

We appreciate your cooperation and understanding of this policy, as it helps us serve all of our patients in a timely manner.
We look forward to your next visit!

Signature:

Date:

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CONSENT TO DENTAL PHOTOGRAPHY

I _____,(Patient Name), authorize Dr. Andrew Blasek and any authorized team members of Blasek Family Dentistry, as well as their designated representatives, to capture photographs, slides, and video recordings of my teeth, jaws, and facial structures before, during, and after treatment.

I understand that these images and recordings will serve as part of my clinical record and may be used for purposes including, but not limited to, communication with other healthcare professionals and educational publications. I further acknowledge that such materials may be utilized for marketing and advertising purposes, including publication on the practice's website and social media platforms such as Facebook and Instagram.

Please initial one option:

_____I do not mind if my photographs are used in any of the above stated situations.

_____I only agree to have my teeth shown without any identifying features.

_____ I decline consent for my photographs and x-rays to be used in any of the above stated situations.

Patient/ Guardian Signature _____ Date _____