Welcome to Kotula Dental!

For Office Use Only	Patient #

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out both sides of this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (Confidential)

Name_____ SS#_____-_____-_____ Birthdate_____/_____/_____

Address_____ City_____ State_____ Zip_____

Email_____ Home Phone (_____)_____ Cell Phone (_____)_____

Check appropriate box: O Minor O Single O Married O Divorced O Widowed O Separated

If Student, Name of School/College_____ City_____ O Full Time O Part Time

Patient's Employer_____ Work Phone (_____)_____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parent/Guardian's Name_____ Employer _____ Work Phone (_____)_____

Person to contact in case of emergency_____ Phone (_____)_____

Whom may we thank for referring you? _____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

Email_____ Home Phone (_____)_____ Cell Phone (_____)_____

Birthdate_____/_____/_____ SS#_____-_____-_____ Employer_____ Work Phone (_____)_____

Is this person a current patient in our office? O Yes O No

Payment is due at time of service. This office does not offer payment plans.

For your convenience, we offer the following payment methods: O Cash O Personal O Check O Visa O Mastercard

Insurance Information

Name of Insured_____ Relationship to Patient_____

SS#_____-_____-_____ Birthdate_____/_____/_____ Date Employed_____/_____/_____

Name of Employer_____ Union or Local#_____ Work Phone (_____)_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group#_____ Policy ID#_____

Ins. Co. Address_____ City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit_____

Do you have any additional insurance? O No O Yes, complete the following:

Name of Insured_____ Relationship to Patient_____

SS#_____-_____-_____ Birthdate_____/_____/_____ Date Employed_____/_____/_____

Name of Employer_____ Union or Local#_____ Work Phone (_____)_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group#_____ Policy ID#_____

Ins. Co. Address_____ City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit_____

PLEASE COMPLETE AND SIGN PAGE 2 > > > > > > >>

Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O No O Yes, please explain: _____

Have you ever been hospitalized or had a major operation? O No O Yes, please explain: _____

Have you ever had a serious head or neck injury? O No O Yes, please explain: _____

Are you taking any medications, pills or drugs? O No O Yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? O No O Yes _____

Are you on a special diet? O No O Yes _____

Do you use tobacco? O No O Yes _____

Do you use controlled substances? O No O Yes _____

Are you allergic to any of the following? O Aspirin O Penicillin O Codine O Acrylic O Metal O Latex O Local Anesthetics O Other

If yes, please explain: _____

_____

Women, are you:

- O Pregnant/Trying to get pregnant?
- O Taking oral contraceptives?
- O Nursing?

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O No	O Yes	Excessive Bleeding	O No	O Yes	Mitral Valve Prolapse	O No	O Yes
Alzheimer's Disease	O No	O Yes	Excessive Thirst	O No	O Yes	Pain in Jaw Joints	O No	O Yes
Anaphylaxis	O No	O Yes	Fainting Spells/Dizziness	O No	O Yes	Parathyroid Disease	O No	O Yes
Anemia	O No	O Yes	Frequent Diarrhea	O No	O Yes	Psychiatric Care	O No	O Yes
Angina	O No	O Yes	Frequent Headaches	O No	O Yes	Radiation Treatments	O No	O Yes
Arthritis/Gout	O No	O Yes	Genital Herpes	O No	O Yes	Recent Weight Loss	O No	O Yes
Artificial Heart Valve	O No	O Yes	Glaucoma	O No	O Yes	Renal Dialysis	O No	O Yes
Artificial Joint	O No	O Yes	Hay Fever	O No	O Yes	Rheumatic Fever	O No	O Yes
Asthma	O No	O Yes	Heart Attack/Failure	O No	O Yes	Rheumatism	O No	O Yes
Blood Disease	O No	O Yes	Heart Murmur	O No	O Yes	Scarlet Fever	O No	O Yes
Blood Transfusion	O No	O Yes	Heart Pacemaker	O No	O Yes	Shingles	O No	O Yes
Breathing Problem	O No	O Yes	Heart Trouble/Disease	O No	O Yes	Sickle Cell Anemia	O No	O Yes
Bruise Easily	O No	O Yes	Hemophilia	O No	O Yes	Sinus Trouble	O No	O Yes
Cancer	O No	O Yes	Hepatitis A	O No	O Yes	Spina Bifida	O No	O Yes
Chemotherapy	O No	O Yes	Hepatitis B or C	O No	O Yes	Stomach/Intestinal Disease	O No	O Yes
Chest Pains	O No	O Yes	Herpes	O No	O Yes	Stroke	O No	O Yes
Cold Sores/Fever Blisters	O No	O Yes	High Blood Pressure	O No	O Yes	Swelling of Limbs	O No	O Yes
Congenital Heart Disorder	O No	O Yes	Hives or Rash	O No	O Yes	Thyroid Disease	O No	O Yes
Convulsions	O No	O Yes	Hypoglycemia	O No	O Yes	Tonsillitis	O No	O Yes
Cortisone Medicine	O No	O Yes	Irregular Heartbeat	O No	O Yes	Tuberculosis	O No	O Yes
Diabetes	O No	O Yes	Kidney Problems	O No	O Yes	Tumors or Growths	O No	O Yes
Drug Addiction	O No	O Yes	Leukemia	O No	O Yes	Ulcers	O No	O Yes
Easily Winded	O No	O Yes	Liver Disease	O No	O Yes	Venereal Disease	O No	O Yes
Emphysema	O No	O Yes	Low Blood Pressure	O No	O Yes	Yellow Jaundice	O No	O Yes
Epilepsy or Seizures	O No	O Yes	Lung Disease	O No	O Yes			

Have you ever had any serious illness not listed above? O No O Yes, please explain: _____

_____

Authorization and Release

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 to 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 payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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.

Signature of Patient (or Parent/Guardian if minor)		Date	