116 Belmont Street, Suite 23
Worcester, MA 01605
Phone: (508)755-0751
Fax: (508)755-5532
KozicaDental@verizon.net
www.KozicaDental.com

Consent for Treatment and Financial Agreement

Consent for Treatment

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care. I agree to the use of anesthetics and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patients with Insurance

I understand that any expected payment form my insurance company is an estimate only and that I am responsible for any portion not covered by insurance. I further understand that my estimated portion must be paid in full on the day of the treatment. Any amount not covered by the insurance company is due and payable in full immediately upon notification by the insurer. It is my responsibility to verify my coverage. If payment is not completed as agreed and communication has not been made with the office, Kozica Dental will be forced to turn my account over to a collection agency. All collection charges shall be paid by me (the patient), and Kozica Dental shall not be held liable for any damage to my credit rating.

Patients without Insurance

I understand that payment is expected is expected at time of service. I further understand that any portion not paid at this time is my responsibility. If payment is not completed as agreed and communication has not been made with the office, Kozica Dental will be forced to turn my account over to a collection agency. All collection charges shall be paid by me (the patient), and Kozica Dental shall not be held liable for any damage to my credit rating.

Late Fees

For balances over 30 days, a minimum monthly finance charge of $5.00 will apply to all balances of $350.00 or less, and a monthly finance charge of 1.5% will apply to all balances over $350.00.

Cancellation Fees

It is the policy of this office to charge a fee for the time reserved for patients who miss an appointment or cancel with less than 24-hour's notice.

☒Print Name: _____
☒Patient's Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

I have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (please specify):

_____
_____
_____
_____

Welcome

To help us meet all your healthcare needs, please fill out this form completely.
If you have questions or need assistance, please ask and we'll be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Date

First Name	MI	Last Name	
Street Address	City	State	Zip
Email			
Home Phone	Mobile Phone	Work Phone	Ext.
□ Male □ Female	Check Appropriate Box: □ Married □ Single □ Minor □ Separated □ Divorced □ Widowed		
Birth Date	SS #	Driver's Lic #	
Spouse or Parent/Guardian's Name			
If Student, Name of College	City	State	□ Full Time □ Part Time
Whom May We Thank for Referring You?			
Emergency Contact	Relationship to Patient		
Home Phone	Mobile Phone	Work Phone	Ext.

RESPONSIBLE PARTY

Name of Person Responsible for this Account			
Birth Date	Relationship to Patient		
SS #	Home Phone	Cell Phone	
Address	City	State	Zip
Employer		Work Phone	

Is this Person Currently a Patient in our Office? □ Yes □ No

We accept cash, check, and credit cards. Please pay your portion in full at each appointment. Would you like us to keep a credit card on file? □ Yes If yes, please indicate card type here: □ VISA □ MasterCard □ Discover

Credit Card Number: Expiration: ____ /____ 3-Digit Card Verification Code:

PATIENT DENTAL HISTORY

New Patients Only: Please provide information about your dental history.

Name of Previous Dentist:	Date of Last Exam:
Previous Dentist's Address/Location:	Date of Last Cleaning:
Date of Last X-rays (4BWX):	Date of Last Full Mouth X-Rays (FMX):

PRIMARY INSURANCE INFORMATION

If you have dental insurance, please complete the following:

Name of Insured	Insurance Carrier		
Birth Date of Insured	Date Employment Began		
Subscriber ID #	Relation to Subscriber : □ Self □ Spouse □ Dependent □ Other		
Employer Name	Union or Local #		
Employer Address	City	State	Zip
Insurance Carrier Phone	Group #		

SECONDARY INSURANCE INFORMATION

If you have *additional* dental insurance, please complete the following:

Name of Insured	Insurance Carrier		
Birth Date of Insured	Date Employment Began		
Subscriber ID #	Relation to Subscriber : □ Self □ Spouse □ Dependent □ Other		
Employer Name	Union or Local #		
Employer Address	City	State	Zip
Insurance Carrier Phone	Group #		

PLEASE TURN OVER AND COMPLETE ⟹

PATIENT MEDICAL QUESTIONS

Primary Care Physician: _____ Office Phone: _____ Date of Last Exam: _____

	Yes	No		Yes	No
Are you under medical treatment now?	☐	☐	Are you wearing contact lenses?	☐	☐
Have you been hospitalized for surgery or serious illness within the past 5 years? If yes, please explain: _____ _____	☐	☐	Are you taking any medications, including non-prescription medications? If yes, please list: _____ _____	☐	☐
Have you ever taken Fen-Phen/Redux? Have you taken Viagra, Revatio, Cialis, or Levitra in the past 24 hours?	☐ ☐	☐ ☐	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
Do you use tobacco or drink alcohol?	☐	☐	Do you use controlled substances?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates?	☐	☐	Women Only:		
Do you have **allergies**? If yes, please list:	☐	☐	Are you pregnant or do to you think you may be? Are you nursing? Are you taking oral contraceptives?	☐ ☐ ☐	☐ ☐ ☐

Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Smoke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Alcoholism	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Hay Fever/Seasonal Allergies	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Radiation Therapy	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Recent Weight Loss	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Liver Disease	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Heart Trouble	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Respiratory Problems	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Mitral Valve Prolapse	☐	☐
Herpes or Cold Sores	☐	☐	Other: _____	☐	☐	Other: _____	☐	☐

PATIENT DENTAL QUESTIONS

Please check Yes or No for the following questions:	Yes	No		Yes	No
Do you gums bleed while brushing or flossing?	☐	☐	Do you have frequent headaches?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	Do you clench or grind your teeth?	☐	☐
Are your teeth sensitive to sour liquids or foods?	☐	☐	Do you bite your lips or cheeks frequently?	☐	☐
Do you feel pain in any of your teeth?	☐	☐	Have you had any difficult extractions?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐	Have you had prolonged bleeding after extractions?	☐	☐
Have you had any head, neck, or jaw injuries?	☐	☐	Have you had any orthodontic treatment?	☐	☐
Have you experienced any of the following problems in your jaw?			Do you wear dentures or partials? If yes, date of placement:	☐	☐
			Have you ever received oral hygiene instructions?	☐	☐
Clicking ☐ ☐ Pain (joint/ear/side of face) ☐ ☐ Difficulty opening/closing ☐ ☐ Difficulty chewing ☐ ☐			Do you like your smile?	☐	☐

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 payors 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 dependent's behalf.

X _____ **Date** _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments

_____

_____

_____Signature _____ Date _____