Dental Office of Dr. Ewelina K. Szyszka
510 East Tarpon Avenue, Tarpon Springs, 34689
Phone: (727) 938-9200 Fax: (727) 938-9220

Patient Registration Form

Today's Date ____/____/_____

Is the Patient the Responsible Party: YES NO → IF NO, Your Name: _____

Your Relationship to Patient: _____

TREATED PATIENT INFO

First Name:_____ Last Name:_____ M . I: _____

Date of Birth: _____/_____/_____ Soc Sec: _____ - _____ - _____

Street Address / P.O. BOX: : _____ City, State, ZIP: _____

Sex: MALE FEMALE Primary Reason for Visit: _____

Employment Status: PART-TIME FULL-TIME RETIRED

Student Status (If applicable): PART-TIME FULL-TIME

Marital Status: MARRIED SINGLE DIVORCED SEPARATED WIDOWED

CONTACT INFO

Home Phone: (_____) _____ - _____ Do you consent to us leaving voicemails? YES NO

Cellular: (_____) _____ - _____ I would like to receive text message reminders: YES NO

Work Phone: (_____) _____ - _____ Emergency Contact: (_____) _____ - _____

Email: _____ I would like to receive correspondences via e-mail: YES NO

INSURANCE INFO

Using Dental Insurance? YES NO → IF YES, Is the Treated Patient the Primary Subscriber on the Policy? YES NO

ONLY IF PATIENT IS NOT Policy Holder,
Full Name, Date of Birth of Primary Subscriber? _____, DOB: ____/____/_____

Insurance Company: _____ Insurance Phone # (On Card): __ (_____) _____ - _____

Member #ID: _____ Group Number: _____

Signature of patient, legal guardian:_____Date____/____/_____

(Office) Witness of signature:_____Date: ____/____/_____

Ewelina Szyszka, DDS

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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 OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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OUR MISSION STATEMENT

Financial Agreement

Thank you for choosing Dr. Szyszka's Dental Office to provide your dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest, and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement, please ask our administrative staff.

DENTAL INSURANCE

As a courtesy to you, we will gladly file your insurance claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card with all the information necessary to verify your coverage and file your claim.
- Although we may estimate your insurance benefits, we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, downgrades, waiting period, etc. is entirely YOUR responsibility.
- Receiving our services indicates your acceptance of responsibility to pay your balance in full regardless of our estimate of insurance coverage.
- Your insurance policy is a contact between you, your employer, and the insurance company. All charges not paid by your insurance company are your responsibility regardless of the reason for non-payment. Not all the services we provide are covered benefits.
- Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.

PAYMENT POLICIES

We accept cash, personal & travelers checks, credit & debit cards, including Visa, MasterCard, Discover, and American Express. After dental insurance has paid its portion, a statement is sent to the mailing address on record for the unpaid remaining balance. Payment is expected within thirty (30) days of the statement date. We do not file claims for medical insurance, only dental.

No Insurance Coverage: We provide a written estimate of fees and payment is expected at each visit for the services rendered.

Minor Patients: The parent or guardian accompanying is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment without any expectation. This office will not attempt to collect payment from a parent that is not present at the office during the visit.

Returned Checks: A $25.00 USD card applies when a check is returned by the bank.

Over Due Balance: An account with an unpaid balance past ninety (90) days will be sent to the collection agency. At the time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate on the unpaid balance from the last date of service, attorney fees court fees, and any and other fees associated with the collection of your debt.

Broken or Missed Appointment Policy: Appointments not kept or changed within less than twenty-four (24) hours notice are considered broken. Broken appointments prevent others from receiving the dental care they deserve. We take then seriously for please be considerate and inform us if you need to change your appointment. A charge of $50.00 USD applies for each broken appointment.

Records and Reimbursements: Original records, including radiographs, are property of this office. If you desire we will provide you with a copy of your records or radiographs for a duplication fee of $25.00 USD.

HIPPA: Consent to share appointment, billing, dental information with the person named below:

NAME:_____ **RELATIONSHIP:**_____

I have read the pamphlet attached, titled the Notice of Privacy Practices (HIPPA), effective date of July 2003. **YES** **NO**

I have read the pamphlet attached, titled "My Insurance Covers This, Right?" **YES** **NO**

Patient's Name (printed):_____

Signature of patient, legal guardian:_____ **Date**____/____/_____

(Office) Witness of signature:_____ **Date:** ____/____/_____

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Our mission is to provide our patient with the highest quality of care in a safe, efficient, and comfortable environment.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in any medical status. I authorize the dental staff to perform any necessary dental services, such as x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I also authorize the doctor (and his/her employees for assistance when applicable) to perform any and all forms of treatment, medication, and therapy with my informed consent in connection with my diagnosis and treatment plan. Even though I may have dental insurance coverage, I understand payment for services rendered is my responsibility. It is my understanding that payment is due at the time of service, unless other financial arrangements have been made.

Patient's Name (printed):_____

Signature of patient, legal guardian:_____ **Date**____/____/_____

Staff Signature:_____ **Date:** _____/_____/_____