KERNAGIS
DENTAL EXCELLENCE

DENTAL EXCELLENCE at FISH HAWK

South Shore
Dental Excellence

RICHARD KERNAGIS. DMD • JENNIFER WYNN KERNAGIS. DMD

Welcome to our practice.

Please take a moment to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Today's Date _____

First Name _____ Middle Initial _____ Last Name _____

I prefer to be called (Nickname) _____ ☐ Male ☐ Female

Address _____

Date of Birth _____ Age _____ Social Security No. _____

Home Phone _____ Cell Phone _____ Work Phone _____

Primary Contact Number (please check one) ☐ Home ☐ Work ☐ Cell

E-Mail _____

Whom may we thank for referring you? _____

Payment is due in full at the time of treatment

(unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information including the diagnosis and records of treatment or examination rendered, to my insurance company.

Person to contact in case of emergency:

Name _____ Relationship _____

City/State: _____ Cell Phone _____

Home Phone: _____ Work Phone _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature _____ Date _____

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FINANCIAL AGREEMENT

Thank you for choosing dental excellence at FishHawk for dental care. We are comitted to outstanding dental service with each patient's individual needs in mind. Please take time to read the following and initial each section.

_____ Full payment or your estimated portion is due at the time of service.

_____ We accept cash, checks, Visa/MasterCard, American Express and discover. We also provide low/no cost financing for qualified applicants.

_____ Your Insurance plan is a contract between you and your insurance company. We are not a party to that contract. Dental Excellence at FishHawk will file insurance claims provided you have given us complete insurance information. Please be aware that any balance is your responsibility, whether your insurance company pays or not. In the event we have filed a claim with the information you have provided, and payment is not received within 60 days, the bill will become your responsibility.

_____ During the course of your treatment, it may be necessary to provide services that your insurance company does not cover. The payment of these services is your responsibility. Further determinations of these services are strictly an issue between the insurance company and yourself.

_____ The adult accompanying a child to the dentist is responsible for the payment of these services. This includes guardians, grandparents, siblings, babysitters or any other caregiver given permission to bring the child for services.

_____ Any account over 90 days that goes without payment will be turned over to a collection agency, which is HIPPA compliant and adheres to all current legislation.

_____

Signature of Responsible Party

_____

Date

I, _____ give the following people permission to bring my son/daughter in to this office for dental treatment:

_____ _____

_____ _____

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Acknowledgement of Responsibility to Inform our Office of Contact/Health/Insurance Information Changes and No Show & Cancellation Policy.

If your medical history changes including any drugs, prescription, over the counter or other or if you have had any medical procedures performed or had any symptoms that our office should be made aware of, inform our office prior to the start of any appointment.

If your contact information has changed, including address, phone or email, please inform our office prior to the start of any appointment.

If your insurance coverage has changed, inform our office prior to the start of any appointment.

If a patient does not show for their scheduled appointment or if a scheduled appointment is not cancelled or rescheduled at least 48 hours prior to the originally scheduled appointment, a $50 no show/broken appointment fee may be charged.

By signing below, patient or responsible party acknowledges above patient or responsible party obligation.

_____ _____

Patient or Responsible Party Signature Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

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

_____

Please print name

_____

Signature

_____

Date

OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices but, acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (please specify)

_____

_____

_____

_____

Dental Health History

Patient First Name | Patient Last Name | Date of Birth | Today's Date

Please check Yes or No for those that apply to you:

YES	NO		YES	NO	
o	o	Sensitivity to: Hot Cold Sweet	o	o	Bleeding, Swollen or Irritated Gums
o	o	Chipped/Broken Teeth	o	o	Dissatisfied With Appearance of My Teeth
o	o	Crooked or Tipped Teeth	o	o	Frequent Headaches
o	o	Loose Teeth	o	o	Jaw Joint Pain
o	o	Missing or Spaces Between Teeth	o	o	Grinding or Clenching Teeth
o	o	Catch Food Between Teeth	o	o	Uncomfortable or Uneven When I Bite My Teeth Together
o	o	Dry Mouth or Constantly Thirsty	o	o	Clicking or Popping of Jaw
o	o	Smoke or Use Chewing Tobacco	o	o	Difficulty Opening or Chewing

Please check Yes or No if you have or have had any of the following:

YES	NO		YES	NO	
o	o	Dentures or Partials	o	o	Veneers
o	o	Braces or Clear Braces	o	o	Jaw Surgery
o	o	Periodontal Disease or Gum Treatments	o	o	Root Canals
o	o	Fixed Bridge	o	o	Sleep Apnea
o	o	Dental Implants	o	o	C-PAP Machine or Oral Sleep Appliance
			o	o	Fear or Anxiety About Dental Treatment

If I could change my smile, I would:

- o Make My Teeth Whiter
- o Make My Teeth Straighter
- o Close Spaces or Gaps That Bother Me
- o Replace Dark Metal Fillings With Tooth Colored Fillings
- o Fix My Teeth, So I'm Not Embarrassed When I Smile
- o Repair Chipped Teeth
- o Replace Missing Teeth
- o Replace Old Crowns That Look Dark or Don't Match
- o Have a Smile Makeover
- o Stop My Jaw From Hurting or Clicking

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Tell me about my options for replacing missing teeth with Dental Implants? o Yes o No

Tell me how I can straighten my teeth in less than 2 years and if I'm a candidate? o Yes o No

Have you ever been sedated for dental treatment? o Yes o No

Are you interested in sedation options? o Yes o No

If you could whiten your teeth for an investment anyone could afford, would you be interested? o Yes o No

If this is your first time in our office, please answer the following:

What is the most important thing to you about your dental visit today: _____

How long since your last dental visit? _____

What was done at your last dental visit? _____

Previous Dentist's name: _____

Have you ever had any problems or complications with previous dental treatment? Please explain: _____

_____

Why did you leave your previous dentist? _____

5486 Lithia Pinecrest Road * Lithia, FL 33547 * 813-571-5555 * 813-571-5559 (Fax) * www.sedationdenistrytampa.com

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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DENTAL INSURANCE

Primary Carrier

Insurance Company _____ Insurance Company Phone _____

Address _____

Group No. (Plan or Policy No.) _____

Insured's Name _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's Social Security No _____

Insured's Employer Name _____ Insured's Occupation. _____

Secondary Carrier

Insurance Company _____ Insurance Company Phone _____

Address _____

Group No. (Plan or Policy No.) _____

Insured's Name _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's Social Security No _____

Insured's Employer Name _____ Insured's Occupation. _____

Person Financially Responsible for Account

Name _____ Relationship to Patient _____

Social Security No. _____ Phone _____

Driver's License No. _____ Date of Birth _____

Address _____

Employer _____ Occupation _____

Preference of Payment ☐ Cash ☐ Credit Card

If patient is a minor, name of parent or legal guardian and relationship _____

Is this parent or legal guardian currently a patient in our office? ☐ Yes ☐ No