Sossaman
DENTAL HEALTH AND IMPLANT CENTER

Thank you for selecting our dental health 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 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 _____ Birthdate _____ Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ SS# _____

Check Appropriate Box: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

If Student, Name of School/College _____ City _____ State _____ ❒ Full Time ❒ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Drivers License# _____ Birthdate _____

Employer _____ Work Phone _____ SS # _____

Is this person currently a patient on our office: ❒ Yes ❒ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full or each appointment.

❒ Cash ❒ Personal Check ❒ Visa ❒ Mastercard ❒ I wish to discuss the office's payment policy

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins Co. Address _____ City _____ State _____ Zip _____

Insurance Company Phone Number _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❒ Yes ❒ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins Co. Address _____ City _____ State _____ Zip _____

Insurance Company Phone Number _____

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Dr. Justin Kirch, DDS
Medical Health History

Have you been under the care of a medical doctor during the past two years? ❒ Yes ❒ No

If yes, for what? _____

Physician's Name: _____

Are you allergic or have you had a reaction to the following...

Aspirin, Ibuprofen, or Tylenol	❒ Yes	❒ No
Codeine, Valium or Other Sedatives	❒ Yes	❒ No
Latex or Metals	❒ Yes	❒ No
Local Anesthetic	❒ Yes	❒ No
Penicillin or Other Antibiotics	❒ Yes	❒ No

Have you ever taken any kind of bisphosphonates (Fosamax, Actonel, etc)?

If so, when and how long? _____

Do you use tobacco? ❒ Smoke ❒ Chew

How often? _____ How Long? _____

Are you currently taking any medications, drugs or pills?
❒ Yes ❒ No

If yes, please list name and dosage:

_____

_____

_____

_____

Do you consume alcohol? ❒ Yes ❒ No

How many beverages per week? _____

Do you use any mood altering drugs other than those previously listed?
❒ Yes ❒ No

Do your teeth hurt? ❒ Yes ❒ No

Do your gums bleed when you brush your teeth? ❒ Yes ❒ No

Are you happy with your smile? ❒ Yes ❒ No

Do you like the shade of your teeth? ❒ Yes ❒ No

What would you change? _____

Would you be interested in whitening? ❒ Yes ❒ No

Check yes or no to indicate whether or not you have had or now have the following conditions or treatments:

AIDS	❒ Yes	❒ No	Drug Addiction	❒ Yes	❒ No	Liver Disease	❒ Yes	❒ No
Alcoholism	❒ Yes	❒ No	Emphysema	❒ Yes	❒ No	Mitral Valve Prolapse	❒ Yes	❒ No
Allergies or Hives	❒ Yes	❒ No	Epilepsy or Seizures	❒ Yes	❒ No	Nervous/Anxious	❒ Yes	❒ No
Anemia	❒ Yes	❒ No	Fainting or Dizzy Spells	❒ Yes	❒ No	Neurological Disorders	❒ Yes	❒ No
Arthritis/Rheumatism	❒ Yes	❒ No	Family History of Diabetes	❒ Yes	❒ No	Osteoporosis	❒ Yes	❒ No
Artificial Heart Valve	❒ Yes	❒ No	Fen-Phen or Redox	❒ Yes	❒ No	Psychiatric/Psychological Care	❒ Yes	❒ No
Artificial Joints or Heart Valves	❒ Yes	❒ No	Glaucoma	❒ Yes	❒ No	Radiation Therapy	❒ Yes	❒ No
Asthma	❒ Yes	❒ No	Hay Fever	❒ Yes	❒ No	Rheumatic Fever	❒ Yes	❒ No
Blood Transfusion	❒ Yes	❒ No	Heart Attack	❒ Yes	❒ No	Sickle Cell Disease	❒ Yes	❒ No
Bone Disease or Bone Cancer	❒ Yes	❒ No	Heart Condition	❒ Yes	❒ No	Sinus Trouble	❒ Yes	❒ No
Bruise Easily	❒ Yes	❒ No	Heart Failure	❒ Yes	❒ No	Special or Restricted Diet	❒ Yes	❒ No
Cancer	❒ Yes	❒ No	Heart Murmur	❒ Yes	❒ No	Stroke	❒ Yes	❒ No
Chemotherapy	❒ Yes	❒ No	Heart Pacemaker	❒ Yes	❒ No	Swollen Ankles	❒ Yes	❒ No
Chest Pain (Angina)	❒ Yes	❒ No	Heart Surgery	❒ Yes	❒ No	Thyroid Problems	❒ Yes	❒ No
Chronic Cough	❒ Yes	❒ No	Hemophilla	❒ Yes	❒ No	Tuberculosis (T.B.)	❒ Yes	❒ No
Cold Sores/Fever Blisters	❒ Yes	❒ No	Hepatitis Type _____	❒ Yes	❒ No	Tumors	❒ Yes	❒ No
Congenital Heart Disease	❒ Yes	❒ No	High Blood Pressure	❒ Yes	❒ No	Ulcers	❒ Yes	❒ No
Contact Lenses	❒ Yes	❒ No	HIV Positive	❒ Yes	❒ No	Venereal Disease	❒ Yes	❒ No
Cortisone Medicine	❒ Yes	❒ No	Kidney Trouble	❒ Yes	❒ No	Yellow Jaundice	❒ Yes	❒ No
Diabetes	❒ Yes	❒ No	Latex Sensitivity	❒ Yes	❒ No			

Any disease, condition or problem not listed: _____

Women

Are you pregnant or planning a pregnancy? ❒ Yes ❒ No

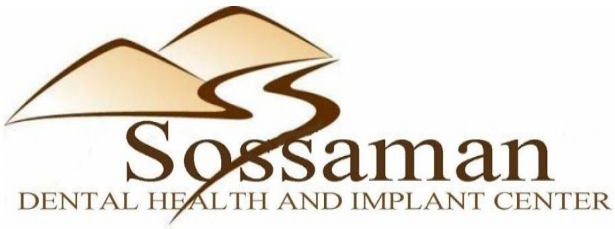
Are you a nursing mother? ❒ Yes ❒ No

If yes, due date: _____

Are you taking birth control pills? ❒ Yes ❒ No

Signature: _____ **Date:** _____ **Check if there are no changes:** ❒

Dr. Signature: _____ **Date:** _____ **Date:** _____



Financial Agreement

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the cost incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient that he/she is personally responsible for payment of all dental services. This office will submit the patient's insurance forms and assist in making collections from insurance companies. Any insurance payment will be credited to the patient's account. Any balance not paid by the insurance will be the patient's responsibility.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for the dental care can only be extended for a period of 6 months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within 5 days of billing if credit is extended. I further agree that a waiver of any breach of may condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment any payment and agree to their content.

Signature of patient, parent, or guardian (responsible party)

Signature: _____ Date: _____

Print Name: _____ Relationship: _____

HIPAA RELEASE FORM

I, _____, authorize the release of information of _____, including the diagnosis, records, examination and treatment rendered to above patient, ledger, and billing, and claims information.

This information may be released to (check one box/boxes)

[ ] Spouse: _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone. (Initial here) _____

In further consideration for this, Sossaman Dental Health and Implant Center agrees to the same stipulations. This **Release of Information** will remain in effect until termination by me in writing.

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:

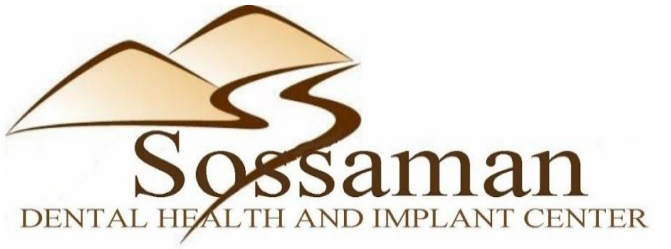
[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] Other _____

The best phone number to reach me is at: _____

Signed: _____ Date:_____



Consent for services

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to me health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist Dr. Kirch to release any information including diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or health practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature:_____ Date: _____

Print Name: _____ Relationship: _____