# Patient Information

Patient Name_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Patient Employer_____ Age_____ D.O.B._____ Marital Status____

Bus #_____ Mobile #_____ E-mail_____

Emergency contact person_____Phone #_____ Relationship_____

May we email or text you with appointment reminders and office information?_____

How did you find out about our office? _____

## Dental History

Last Dental Visit_____ Past major dental treatment_____

How often do you brush? _____ How often do you floss?_____

What did you like most about your former dental office?_____

What do you like least about going to the dentist?_____

**Please place a check mark next to any dental problem that you are experiencing.**

| | | |
|---|---|---|
| __Bleeding Gums | __Grinding Teeth | __Sensitivity to Hot |
| __Sores in Mouth | __Jaw Pain | __Sensitivity to Cold |
| __Bad Breath | __Broken Fillings | __Sensitivity to Biting |
| __Receding Gums | __Loose Teeth | __Sensitivity to Sweets |

Do you like your smile?____ Would you like whiter teeth?____

How can we help you?_____
_____

# Medical History

Patient Name_____Date_____

Medical Doctor's Name_____ Doctor's phone #_____

Please describe any serious illness or any operations you have or have had_____

**Please place a check mark next to any condition below that you have now or have *ever* had in the past.**

__AIDS
__Anemia
__Asthma
__Blood Disease
__Cancer
__Chemotherapy
__Cortisone Treatment
__Diabetes
__Epilepsy
__Fainting
__Heart Murmur
__Hepatitis
__High Blood Pressure
__HIV Positive
__Kidney Disease
__Liver Disease
__Radiation Therapy
__Rheumatic Fever
__Shortness of Breath
__Stroke
__Thyroid Problems
__Tobacco Habit
__Sexually Transmitted Disease

**Please place a check mark next to any condition that you *currently* have.**

__Cardiovascular conditions
__Artificial Heart Valves
__Heart Murmur
__Shortness of Breath
__Chest Pain
__Edema (swelling of legs or ankles)
__Tiredness
__Palpitations
__High Blood Pressure

__Respiratory conditions
__Cough
__Phlegm
__Cough up Blood
__Shortness of Breath
__Chest Pain
__Wheezing
__Tuberculosis
__Emphysema

__Gastrointestinal conditions
__Sudden Weight Loss or Gain
__Change in Appetite
__Difficulty Swallowing
__Abdominal Pain
__Change in Bowel Habits
__Diarrhea
__Diabetes
__Unexplained Vomiting

__Genitourinary conditions
__Pain During Urination
__Frequent Nighttime Urination
__Blood in Urine
__Constant feeling of Urination
__Pregnancy

__Neurological conditions
__Headaches
__Seizures
__Visual Disturbances
__Weakness/Tingling/Numbness
__Difficulty in Urination

__Musculoskeletal conditions
__Pain in Joints
__Artificial Joints
__Swelling in Joints
__Arthritis
__Loss of Coordination

Do you have any allergies to any medications?___ If so, which ones?_____

Does skin react to any type of jewelry, metals or latex?_____

Explain your allergic reaction to these medications._____

Please list any medications that you are currently taking and for what conditions, including over-the-counter drugs, and the dosage if known_____

**Do you have any other medical condition that has not been covered above?**_____ If so, please discuss with the doctor.

The medical history described above is complete to the best of my knowledge.

Signature of Patient or Guardian_____Date_____

Mark Kupec D.D.S., P.C.

## Our Service Agreement

Dear Patient,

We appreciate you choosing our office as your dental health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to maintain your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask for our assistance.

We ask that **all** patients read and sign our Financial Policy as well as complete our Patient Information Form Prior to seeing the doctor.

Payments for services are due at the time of treatment. We accept cash, checks, and for your convenience, Visa, Mastercard, Discover and Care Credit. For patients who are children of divorce, the parent or guardian who brings the child to the appointment is responsible for payment.

As a **courtesy** to our patients**,** we will gladly file your insurance claims as long as we have the most current insurance information.

By signing below, you authorize Mark Kupec, DDS, and PC to accept **1. Assignment of Primary Insurance** and **2. Release of Information** as necessary requirements to process your claim as outlined by your insurance policy. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company.
2. All charges are your responsibility whether your insurance company chooses to pay or not. Not all services are covered benefits in all contracts. Some insurance companies pick and choose which services they will cover.
3. All estimated charges along with unpaid deductibles are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 60 days of date of service, we require you to pay the balance with cash, check or credit card.
5. Returned checks are subject to a $35 charge.
6. Balances older than 60 days may be sent to an outside collection agency.
7. We do not accept payment from any secondary insurance carrier.

**If you are unable to keep any appointment, please give us 1 business day (Mon.- Thurs.) notice so the time that we reserved for you can be made available to treat another patient who is in need. We reserve the right to charge a missed appointment fee for appointments missed without adequate notice.**

**Any appointment 1.5 hours long or longer will require a deposit of 20%. The deposit will be applied to the appointment unless the appointment is missed without adequate notice.**

We understand that temporary financial problems may affect timely payment. Therefore, we encourage you to communicate any such problems so that we can assist you in the management of your account. **However, if your account becomes past due (after 30 days from the date of service), we will take all the necessary steps to collect the debt. If we have to refer your account to a collection agency, you agree to pay all the collection fees that are incurred.**

We appreciate your trust in us and hope to provide you with the ultimate care you deserve.

Patient/Guardian Address_____

Patient/Guardian Signature_____Date_____

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.**

**As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.**

**We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.**

- **Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.**
- **Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.**
- **Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, audit functions, cost management analysis, and customer service. An example would be an internal quality assessment review.**

**We may also create and distribute de-identified health information by removing all references to individually identifiable information.**

**We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.**

**Any other uses and disclosures will be made only with your written authorization. You may revoke such written authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.**

**You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to Dr. Kupec, the Privacy Officer:**

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.**
- **The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.**
- **The right to inspect and copy your protected health information. Cost of copying dental records are $30 that include the first 10 pages, $1 for pages 11-60, $.50 for pages 61-400 and $.25 for remaining pages, and actual costs of mailing/shipping. Costs of x-ray duplication are $15 for full mouth series or panoramic x-rays, $10 for bitewing x-rays, and $5 for single x-rays.**
- **The right to amend your protected health information.**
- **The right to receive an accounting of disclosures of protected health information.**
- **The right to obtain a paper copy of this notice from us upon request.**

**We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.**

**This notice is effective as of April 14th, 2003 and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.**

**You have recourse if you feel that your privacy protections have been violated. You have a right to file a written complaint with our office; if the complaint is not resolved within our office you may forward the complaint to: Region VI, Office of Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202. Phone (214) 767-4056; Fax (214) 767-0432; TDD (telecommunications Display Device) (214) 767-8940.**

Mark Kupec D.D.S
Copper Ridge Dental
7600 West Highway 29, Suite 9
Georgetown, Texas 78628
(512) 930-7645

# Acknowledgement Of Receipt Of Notice Of Privacy Practices

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

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Print name

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Signature Date

I authorize the following person(s) to discuss my protected health information:

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## For Our Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

_____Patient refused to sign

_____Communication barriers prohibited obtaining acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (Describe below)

# Sleep Disorder Assessment

**Patient Name:**_____ **Date of Birth:** _____

**Physician Name:**_____ **Physician Number:** _____

1. Have you ever been given a CPAP device?..... Yes___No___
2. If you have been given any form of CPAP, do you use it nightly?..... Yes___No___
3. Are you comfortable with your CPAP and satisfied with its use?..... Yes___No___

***If the answer is "Yes" to all three questions, YOU ARE DONE!***

If your answer is **"No"** to any of the above questions, please continue to ***Part 1***.

***Part 1*** ***Epworth Sleepiness Scale***

How likely are you to doze off while doing the following activities? Please use the following scale: 0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more. …….. 0 1 2 3
2. Sitting and talking to someone…… 0 1 2 3
3. Sitting and reading…….. 0 1 2 3
4. Watching TV……... 0 1 2 3
5. Sitting inactive in a public place……. 0 1 2 3
6. Lying down to rest in the afternoon……... 0 1 2 3
7. Sitting quietly after lunch without alcohol…….. 0 1 2 3
8. In a car, while stopped for a few minutes in traffic……. 0 1 2 3

Total ESS: ____

For Office Use Only:

Total score:

Initials:

***Part 2***

1. Have you been told that you snore?..... Yes___No___
2. Does your family have a history of premature death in sleep?..... Yes___No___
3. Do you have diabetes?..... Yes___No___
4. Have you ever been told you have coronary artery disease?..... Yes___No___
5. Do you have high blood pressure?..... Yes___No___
6. Have you ever experienced irregular heart rhythms?..... Yes___No___
7. Do you have anxiety or depression?..... Yes___No___
8. Do you have difficulty falling or staying asleep?..... Yes___No___

***Part 3***

1. Have you ever been diagnosed with sleep apnea? …….. Yes___No___
2. Do you awaken from sleep with chest pain or shortness of breath? Yes___No___
3. Has anyone said that you seem to stop breathing while sleeping? .. Yes___No___
4. Is your neck size larger than 15" (female) or 16.5" (male)?..... Yes___No___
5. Have you ever had a stroke?..... Yes___No___
6. Have you ever been told you have congestive heart failure?..... Yes___No___
7. 7. Do you have or did you ever have atrial fibrillation?..... Yes___No___

Actual Neck Size:

_____ _____

Patient/Signature Date