PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____

Birth Date: _____ Age: _____ Sex: ☐ M ☐ F ☐ Single ☐ Married ☐ Divorced

☐ Widowed ☐ Separated ☐ Minor Spouse's Name: _____

S.S # _____ Driver's License: _____

Employer's Name: _____ Occupation: _____

Home Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Work: _____ Cell: _____

Email Address: _____ Best way to reach you: _____

Emergency Contact Name: _____ Phone: _____

How did you hear of us? _____

If referred by someone, whom May We Thank for the Referral _____

PARENT/GUARDAIN INFORMATION (IF PATIENT IS A MINOR)

Name: _____ Relationship to the patient: _____

Birth Date: _____ SS#: _____ Driver's License: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone#: _____ Cell Phone: _____ Email Address: _____

DENTAL INSURANCE INFORMATION (DO NOT SKIP THIS STEP)

	Primary Carrier	Secondary Insurance
Name of Insurance Company:		
Insurance Phone Number:		
Policy Number or Social :		
Policy Holder's Name:		
Birth Date:		
Group Number:		
Employer:		
Relationship to Policy Holder:	**Self____Spouse____Child____ Other ____**	**Self____Spouse____Child____ Other ____**

DENTAL HISTORY

Do you like your smile? Yes _____ No_____ what, if anything, would you change about your smile?

_____

Reason for today's visit: _____

Last dental visit: _____ Last dental X-rays: _____

Are you interested on Teeth Whitening? Yes____ No ____

Are any of your teeth moving? Yes ____ No ____

Are you currently in pain? Yes _____ No_____

Do you now have or have you ever experienced pain or discomfort in your jaw (TMJ)? Yes _____ No _____

Check if you have had any of the following: (Mark yes or no)

Yes ☐ No ☐ Bad Breath Yes ☐ No ☐ Food collection between teeth Yes ☐ No ☐ Sensitivity to heat

Yes ☐ No ☐ Bleeding gums Yes ☐ No ☐ Loose teeth /broken fillings Yes ☐ No ☐ Sensitivity to sweets

Yes ☐ No ☐ Clicking or popping jaw Yes ☐ No ☐ Periodontal treatment Yes ☐ No ☐ Sensitivity when biting

Yes ☐ No ☐ Sores in your mouth Yes ☐ No ☐ Sensitivity to cold Yes ☐ No ☐ Grinding teeth

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

MEDICAL HISTORY

Do you have a Primary Care Physician? ☐ Yes ☐ No Physician Name: _____

Phone Number: _____ Date of last visit: _____

Have you ever had any serious illness or operation? ☐Yes ☐ No Describe _____

Have you ever been hospitalized? ☐ Yes ☐ No Describe _____

Do you have any metal rods, pins or implants? ☐ Yes ☐ No Describe _____

Have u ever taken Phen –Fen? ☐ Yes ☐ No

Have you ever taken Fosamax or any other Bisphosphanate? ☐ Yes ☐ No If so when? _____

Are you taking any prescription/drugs/over the counter drugs? ☐ Yes ☐ No if yes, please list each one:

_____

(Women) Are you pregnant? ☐ Yes ☐ No if so, how many months ____ Are you Nursing ☐ Yes ☐ No

ARE YOU SENSITIVE OR ALLERGIC TO THE FOLLOWING MEDICATIONS?

Yes ☐ No ☐ Penicillin Yes ☐ No ☐ Tetracycline Yes ☐ No ☐ Erythromycin Yes ☐ No ☐ Asprin

Yes ☐ No ☐ Codine Yes ☐ No ☐ Sulfa Drugs Yes ☐ No ☐ Latex Yes ☐ No ☐ Dental Anesthetics

If other, what medications? _____

Do you have a disease, condition or problem not listed that you think I should know about? _____

_____

CHECK IF YOU HAVE / HAD ANY OF THE FOLLOWING: (Mark your answers)

Yes ☐ No ☐ Aids	Yes ☐ No ☐ Epilepsy	Yes ☐ No ☐ Liver Disease
Yes ☐ No ☐ Anemia	Yes ☐ No ☐ Fainting	Yes ☐ No ☐ Mitral Valve
Yes ☐ No ☐ Arthritis, Rheumatism	Yes ☐ No ☐ Glaucoma	Yes ☐ No ☐ Pacemaker
Yes ☐ No ☐ Artificial Heart Valves	Yes ☐ No ☐ Heart Attack	Yes ☐ No ☐ Psychiatric Care
Yes ☐ No ☐ Artificial Joints (Bones)	Yes ☐ No ☐ Headaches	Yes ☐ No ☐ Rheumatic fever
Yes ☐ No ☐ Asthma	Yes ☐ No ☐ Herpes/Fever Blisters	Yes ☐ No ☐ Sinus Problems
Yes ☐ No ☐ Cancer/Chemotherapy	Yes ☐No ☐ Hemophilia	Yes ☐ No ☐ Stroke
Yes ☐ No ☐ Chemical Dependency	Yes ☐ No ☐ Heart Murmur	Yes ☐ No ☐ Swelling of Feet
Yes ☐ No ☐ Circulatory Problems	Yes ☐ No ☐ HIV Positive	Yes ☐ No ☐ Scarlet Fever
Yes ☐ No ☐ Congenital Heart Disease	Yes ☐ No ☐ High Blood pressure	Yes ☐ No ☐ Seizures
Yes ☐ No ☐ Cortisone Treatments	Yes ☐ No ☐ Hepatitis	Yes ☐ No ☐ Thyroid Problems
Yes ☐ No ☐ Cough, Persistent	Yes ☐ No ☐ Jaw Pain	Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Diabetes	Yes ☐No ☐ Kidney Disease	Yes ☐ No ☐ Tobacco Habit
Yes ☐ No ☐ Difficulty Breathing	Yes ☐ No ☐ Lupus	Yes ☐ No ☐ Venereal Disease

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____ _____

Date **Patient Signature**

Parent/Guardian Signature **if Patient is a minor:** _____ **Date:** _____

Dentist signature: _____ **Date:** _____

CONSENT FOR SERVICES

I, the undersigned, have insurance with_____

Name of Insurance Company(s)

And assign directly to THE KILZI DENTAL CORP all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. ***All Financial arrangements must be made in advanced, prior to your appointment.*** An estimate of financial responsibility on the part of each patient will be determined before treatment. Any treatment recommendations are made based on what is best for you, our patient; treatment is not recommended based on what will or will not be covered by your insurance. We will do our best to give you an accurate estimation for what will be paid by your dental insurance, but we cannot guarantee what they will pay. It is our policy to collect patient's estimated portion at the time of service.

I have read and understand the above conditions of treatment and payment; I agree and give my consent for treatment.

_____ _____

Date **Patient Signature**

CANCELLATION AND BROKEN APPOINTMENTS 24 –Hour notice is required when canceling or rescheduling an appt. There could be a charge applied to your account if an appointment is cancelled with less than 24-hours notice. Failure to show for an appt does not release the obligation for the time. We are very understanding of unusual circumstances; however chronic failure of appointments is not compatible with our type of practice where the times are reserved. Initials: _____

POLICY OF PAYMENT

Payment is due at the time of treatment. We accept cash, check and major credit cards. We also have a Third party Finance called CareCredit that allows you to start treatment today and spread payments over time without interest, applying for it only takes a few minutes and there is no application fee, ask us to process the application for you. We do accept dental insurance; however, the patient portion is due at the time of treatment.

I understand that payment is due at the time of service, unless previously arranged.

Patient Signature: _____ Date: _____

I have received a copy of the Dental Materials Fact Sheet as required by law.

_____ _____

Date **Signature**

Next Visit

Medical History Updates

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

If yes, please explain?

_____

_____ _____

Date Patient/Guardian Signature

_____ _____

Date Dentist Signature

Medical History Updates

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

If yes, please explain?

_____

_____ _____

Date Patient/Guardian Signature

_____ _____

Date Dentist Signature

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.
What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:
1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office.

Kilzi Dental Corp
1113 South Main Street, Suite B,
Corona, CA 92882
(951)739-0752

Appointment Cancellation Policy Agreement

Please provide our office with 48-hour notice to change or cancel an appointment. Cancellations with less than 24 hours' notice are difficult to fill, Dr. Kilzi is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, or no notice at all, prevent another patient from being seen and leave a 60-minute hole in the Doctor's schedule. **Please call us at (951) 739-0752 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday.** If prior notification is not given, you will be charged **$20.00** for the missed appointment. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

Thank you for providing our office and our patients with this courtesy. I have read, understand, and agree to abide by the policy above:

Please sign below to consent to these terms.

_____

Print Name

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

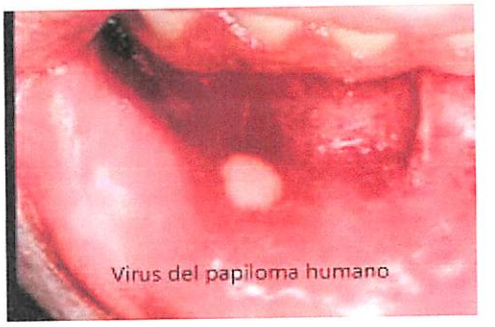
Date

KILZI DENTAL CORP.

Adjunctive Oral Cancer Screening Acceptance Form

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.



Late detection in oral cancer is the primary reason the mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk factors.** There are now more studies that link HPV virus with the increase of oral cancer.

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you. **The fee for the enhanced examination is ~~$55.00~~ now $50.00.**

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for the enhanced examination.

Print Name: _____

Signature: _____ Date: _____

No. I would prefer not to have the ViziLite Plus exam at this time.

Print Name: _____

Signature: _____ Date: _____

ORAL CANCER FACTS

48,250 AMERICANS WILL BE DIAGNOSED WITH ORAL CANCER THIS YEAR ALONE.

WORLDWIDE THE PROBLEM IS MUCH GREATER, WITH NEW CASES EXCEEDING 640,000 ANNUALLY.

THE FASTEST GROWING SEGMENT OF THE ORAL/ OROPHARYNGEAL CANCER POPULATION, ARE HPV16+ YOUNG NON-SMOKERS.

ONE PERSON WILL DIE EVERY HOUR OF EVERY DAY 24/7/365 FROM ORAL CANCER IN THE US.

TOBACCO USE IN ALL OF ITS FORMS AND ALCOHOL ARE STILL MAJOR RISK FACTORS FOR ORAL CANCER.

SIGNS AND SYMPTOMS

. RED AND/OR WHITE DISCOLORATIONS OF THE SOFT TISSUE OF THE MOUTH

. ANY SORE WHICH DOES NOT HEAL WITHIN 14 DAYS

. HOARSENESS WHICH LASTS FOR A PROLONGED PERIOD OF TIME

. A SENSATION THAT SOMETHING IS STUCK IN YOUR THROAT WHEN SWALLOWING

. UNEXPLAINED NUMBNESS IN THE MOUTH

. EAR PAIN THAT OCCURS ON ONE SIDE ONLY

. A SORE UNDER A DENTURE, WHICH EVEN AFTER ADJUSTMENT OF THE DENTURE, STILL DOES NOT HEAL

. A LUMP OR THICKENING THAT DEVELOPS IN THE MOUTH OR ON THE NECK

To learn more, please visit: www.oralcancer.org

THE ORAL CANCER FOUNDATION

THE BRUCE PALTROW ORAL CANCER FUND