Koplon Implant and Family Dentistry

www.koplondmd.com
8125 Parkway Drive, SE • Leeds, AL 35094
Info@Koplondmd.com
(205)699-2551

Welcome to our Practice
Scott Koplon DMD
Adam Koplon DMD

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (M) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-_____ (Zip Code)

DL#: _____

Please enter Employer and Occupation

_____

_____

Whom may we thank for referring you to our practice?

_____

Responsible Party Information:

Please enter information for the person financially responsible for the account

Please indicate Responsible Party *

○ I am financially responsible for this account--Skip this section and continue to the next section.

○ Other--Please fill out information below

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: _____ (Last) _____ (First) ___ (M) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-_____ (Zip Code)

Dental Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ___ (M)

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-_____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-_____ (Zip Code)

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-_____ (Zip Code)

Insurance Company Phone Number: _____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured: * _____ (Last) * _____ (First) ___ (M)

Insured's Birth Date:* _____ **ID #:*** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name:* _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured:* ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name:* _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Company Phone Number: _____

Dental History Information

What is the reason for your visit today?

_____

_____

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

_____

_____

Date of most recent dental exam and dental x-rays:

_____

_____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Is there anything about your smile you would like to change? If yes, what would it be?

_____

_____

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Have dry mouth
- ☐ Food gets trapped between any teeth
- ☐ Have popping and/or clicking of your jaw joint
- ☐ Clench or grind your teeth
- ☐ Gums bleed when brushing or flossing
- ☐ Have or had gum recession
- ☐ Have or had a burning sensation in your mouth
- ☐ Had trouble getting numb
- ☐ Had or have braces (orthodontic treatment)
- ☐ Teeth are sensitive to hot, cold, biting or sweets
- ☐ Have whitened or bleached your teeth
- ☐ Have difficulty chewing
- ☐ Wear or have worn a bite appliance
- ☐ Have been treated for gum disease
- ☐ Had an unpleasant taste or odor in your mouth
- ☐ Snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs 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 in full 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 and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

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 this dental care can only be extended for a period of six 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 five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or 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.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

(Please enter name and relationship to patient.)

_____

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Name of person filling out this form: *

_____

_____

Relationship to patient: *

☐ Self ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Legal Guardian ☐ Other

Response Date: _____

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Medical History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre Med
- ☐ Allergy-Amoxicillin
- ☐ Allergy-Clindamycin
- ☐ Allergy-Codeine
- ☐ Allergy-Erythromycin
- ☐ Allergy-Fluoride
- ☐ Allergy-Keflex
- ☐ Allergy-Latex
- ☐ Allergy-Lodine
- ☐ Allergy-NSAID
- ☐ Allergy-Penicillin
- ☐ Allergy-Phenergan
- ☐ Allergy-Seasonal
- ☐ Allergy-Sulfur
- ☐ AllergyTetracycline
- ☐ Allergy-Tramadol
- ☐ Anemia
- ☐ Art. Heart Valve
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Aspirin/Ibuprofen
- ☐ Asthma
- ☐ AutoImmune
- ☐ BISOPRLOL
- ☐ Blood Disease
- ☐ Blood Disorder
- ☐ Bronchiectusis
- ☐ Bronchiectusis
- ☐ Cancer
- ☐ Cefuroxime
- ☐ Cipro
- ☐ coesoft
- ☐ Congen. Heart Defect
- ☐ COPD
- ☐ Crohns Disease
- ☐ Defibrillator
- ☐ Diabetes
- ☐ Dizziness
- ☐ EPI Sensitivity
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ General Anesthesia
- ☐ Glaucoma
- ☐ Graves Disease
- ☐ Growths/Tumors
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hypothyroid
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Leviquin
- ☐ Lewy Body Disease
- ☐ Liver Disease
- ☐ Local Anesthesia
- ☐ Lupus
- ☐ Mental Disorders
- ☐ Mitro-Valve Prolapse
- ☐ MS
- ☐ MVP
- ☐ Nervous Disorders
- ☐ Other
- ☐ Parkinsons
- ☐ PTSD
- ☐ Radiation Treatment
- ☐ Reactions to Metal
- ☐ Reactions to Nitrous
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ STD / HPV
- ☐ Steriod
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Taking Cumadin
- ☐ Tuberculosis
- ☐ Tylenol
- ☐ Ulcers

☐ FEMALE: Pregnant or Planning Pregnancy ☐ FEMALE: Nursing

If any conditions or alerts selected above need further clarification, please describe below (including due date if pregnant):

_____

_____

_____

Do you have a history of alcohol or drug abuse? * ◯ Yes ◯ No

Do you use Tobacco or Nicotine? If yes, check all that apply;

☐ Smoking ☐ Chewing ☐ Vaping

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you take antibiotic premedication for your dental visits? If yes, please explain below. * ◯ Yes ◯ No

PRE-MED

Are you taking any medications (prescription and non-prescription) including regular doses of aspirin or birth control pills? If yes, please list below. *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

Have you taken or are you taking any Bisphosphonate drug used to treat osteoporosis or Paget's disease? Examples; Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa, Prolia etc. If yes, please enter the drug in the Medications list above. *

◯ Yes ◯ No

Do you have any allergies not listed above (including allergies to medications)? If yes, please explain below * ◯ Yes ◯ No

Name and phone number of your Physician:

Name and phone number of preferred Pharmacy:

In an emergency who should be notified? Please enter Name and Phone number below:

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

☐ *By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

****FOR EXISTING PATIENTS ONLY****
PLEASE REVIEW AND MAKE ANY NECESSARY UPDATES