Derkasch
DENTAL HEALTH ASSOCIATES
William J. Derkasch, DDS

DERKASCH DENTAL HEALTH ASSOC.
REGISTRATION:

Patient Name:_____ **D.O.B:** _____ **SS#:**_____

Address: _____ **City, State, Zip :** _____

Mobile Phone: (___)_____-_____ **Work Phone:**(___)____-_____X____ **Home Phone:**(___)____-_____

Marital Status: S M D W Gender: _____ **Full Time Student** ☐Y ☐N **School Name:** _____

E-Mail:_____ **Driver License #:** _____

Emergency Contact: _____ **Relationship:** _____

EMPLOYMENT INFORMATION PRIMARY

EMPLOYER: _____ **ADDRESS:** _____

CITY, STATE, ZIP:_____ **TELEPHONE#:** _____

PRIMARY DENTAL INSURANCE INFORMATION:

Company: _____ **Telephone:**_____ **Group #:**_____

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

Name of Insured: _____ **Insured SSN:** _____

Insured Date Of Birth: _____ **Relationship to Patient:**_____

Driver's License #:_____ **E-Mail:**_____

EMPLOYMENT INFORMATION SECONDARY

EMPLOYER:_____ **ADDRESS:** _____

CITY, STATE, ZIP: _____ **TELEPHONE#:** _____

SECONDARY DENTAL INSURANCE INFORMATION:

Company: _____ **Telephone:** _____ **Group#:**_____

Address: _____ **City, State, Zip:**_____

Name of Insured_____ **Insured SSN:**_____

Insurer Date Of Birth:_____ **Relationship to Patient:**_____

Driver's License #:_____ **E-Mail:**_____

CONSENT TO TREATMENT: I UNDERSIGNED, HEREBY AUTHORIZE AND DERKASCH AND LICENSED STAFF TO TAKE RADIOGRAPHS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS. I ALSO AUTHORIZE DERKASCH AND STAFF TO PERFORM ANY NECESSARY DENTAL TREATMENT OR THERAPY, OR ADMINISTER MEDICATION, WITH MY INFORMED CONSENT, THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK, AND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY GENERAL HEALTH AND MEDICAL STATUS.

PATIENT, PARENT, OR AUTHORIZED GUARDIAN'S SIGNATURE:_____ **DATE:**_____

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MEDICAL AND DENTAL HISTORY

It is very important that we know your Medical and Dental history. These facts have a direct bearing on your Dental Health and any treatment that we may provide you. This information is strictly confidential, and will not be released to anyone. Thank you for taking the time to COMPLETELY and ACCURATELY fill out this questionnaire.

(PATIENTNAME):_____ **DATE:** _____

Do you have a personal physician? ☐Y ☐N **Name:**_____ **Last Visit:**_____

Physician's address:_____ **Physician's Phone #:**_____

Your current physical health is: ☐Good ☐Fair ☐Poor **Are you currently under the care of a physician?** ☐Y ☐N

If yes, for what?_____

Are you currently taking any PRESCRIPTION or OVER THE COUNTER medications? ☐Y ☐N

Please list all medications and dosages:_____

_____

For women: Are you taking Birth Control Pills? ☐Y ☐N **Are you Pregnant?** ☐Y ☐N **Are you Nursing?** ☐Y ☐N

Have you ever been hospitalized or treated for any reason?_____

Email Address: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

☐Y ☐N Heart attack / Stroke
☐Y ☐N High or Low Blood Pressure
☐Y ☐N Congenital Heart Defect
☐Y ☐N HIV Positive / Aids
☐Y ☐N Blood Transfusion
☐Y ☐N Sinus Problems / Hay Fever
☐Y ☐N Sexually Transmitted Diseases
☐Y ☐N Anemia / Blood Disorders
☐Y ☐N Diabetes / Thyroid Disease
☐Y ☐N Severe / Frequent Headaches
☐Y ☐N Heart Surgery / Pacemaker
☐Y ☐N Angina / Difficulty Breathing
☐Y ☐N Rheumatic / Scarlet Fever
☐Y ☐N Hepatitis – Type?_____
☐Y ☐N Drug or Alcohol Abuse

☐Y ☐N Allergies / Hives
☐Y ☐N Fever Blisters / Shingles
☐Y ☐N Ulcers / Colitis
☐Y ☐N Arthritis / Rheumatism
☐Y ☐N Glaucoma
☐Y ☐N Mitral Valve Prolapse
☐Y ☐N Heart Murmur
☐Y ☐N Asthma / Emphysema
☐Y ☐N Tuberculosis
☐Y ☐N Artificial Bones/Joints/Valves
☐Y ☐N Liver Disease / Jaundice
☐Y ☐N Hemophilia
☐Y ☐N Abnormal Bleeding / Bruising
☐Y ☐N Epilepsy / Seizures
☐Y ☐N Fainting Spells

☐Y ☐N Cancer
☐Y ☐N Chemotherapy / Radiation
☐Y ☐N Psychiatric Treatment
☐Y ☐N Nervousness
☐Y ☐N Kidney Problems
☐Y ☐N Lupus

Are you allergic or have you reacted adversely to the following drugs / substances?:

☐Y ☐N Penicillin
☐Y ☐N Tetracycline
☐Y ☐N Erythromycin
☐Y ☐N Aspirin
☐Y ☐N Latex Products
☐Y ☐N Codeine
☐Y ☐N Dental Anesthetics
☐Y ☐N Other (see below)

Please list:

_____
_____
_____
_____

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DENTAL HISTORY

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DENTAL HISTORY:

Name of previous dentist:_____ **Phone #:**_____

Address:_____

Last visit date:_____ **Last exam date:**_____ **Last Full Mouth X-rays/Panoramic Film:**_____

Why have you come to see us today?_____

Is your current dental health: ☐Good ☐Fair ☐Poor **Do you like your smile?** ☐Y ☐N

If no, why?_____

Have you ever had a serious / difficult problem associated with any previous dental work? ☐Y ☐N

If yes, please explain:_____

Do you have or have you ever had any of the following dental related problems?

Y☐ N☐ Dental Phobia / Apprehension / Fear

Y☐ N☐ Discolored Teeth

Y☐ N☐ Grind or Clench your Teeth

Y☐ N☐ Gums Bleed or Feel Irritated

Y☐ N☐ Tooth Sensitivity to: Hot / Cold / Sweets / Air / Pressure / Other (please list):_____

Y☐ N☐ Headaches / Earaches / Neck pain

Y☐ N☐ Pain / Discomfort in Jaw Joint (TMJ)

Y☐ N☐ Broken teeth / Fillings

Do you Smoke / Use Chewing Tobacco? Y N **If yes, list frequency:**_____

How long have you Smoked / Used Chewing Tobacco?_____

Times you floss per week_____ **Times you brush per day**_____ **Type of brush:** Soft / Med / Hard / Electric

Are you interested in improving your Home Care and Overall Dental Health? Y☐ N☐

I CERTIFY THAT THE INFORMATION I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST OF CONFIDENCE, AND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I WILL NOT HOLD DR. DERKASCH, OR ANY OTHER MEMBER OF THEIR STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

PATIENT, PARENT OR AUTHORIZED GUARDIAN

SIGNATURE:_____ DATE:_____

WILLIAM J. DERKASCH DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

A copy of Derkasch Dental Health Assoc. HIPPA and Privacy Practice Form is Posted in the Office if you should need a copy, please request one from our staff.

I, _____, have been offered a copy of this office's Notice of Privacy Practices. {Please print name}

_____
{signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, Discover, American Express, Optima, and Care Credit. We will be happy to help you process your insurance claim form for your reimbursement. In most cases, we are able to file your claim electronically, which does not require a claim form. In the instances that we are unable to do so, we require that you bring a completed insurance form at the time of the visit. In special instances we may accept assignment of insurance benefits, however, deductibles and estimated copayments must be paid at the time of service. ***Balances' remaining after each insurance claim is settled are due immediately***. You will be billed for any amounts sent to your insurance carrier if not settled within 60 days.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.33% per month (16% APR), or a minimum billing charge of $1.00. Balances older than 90 days will be turned over to Collection Services, and will be subject to legal action. **A charge will also be made for broken appointments and appointments cancelled without 48 hours advance notice. This charge will equal the amount of the cost of the procedures scheduled in the time slot of the missed/cancelled appointment.** In addition we reserve the right to change or refuse credit terms at any time.

We are glad to discuss your proposed treatment and answer any questions related to your insurance. You must realize, however:

1. Your insurance company (Employer Dental Benefit Program) is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR". "UCR" is defined as usual, customary, and reasonable fees for this region. Thus, our fees are considered usual, customary, and reasonable by most companies.
   This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Please refer to your insurance manual for additional information.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems to arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

By signing below, you acknowledge that you understand the above statement, and agree to the terms listed therein.

Patient, Parent, or Authorized Guardian signature:_____ **Date:**_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize Dr.. Derkasch to provide any insurance company(s), Claim Administrator(s), and consulting Health Care Professional(s), information concerning healthcare, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize the payment of dental of medical benefits otherwise payable to me, to Dr. Derkasch.

By signing below, you acknowledge that you understand the above statement and agree to the terms listed therein:

Patient, Parent, or Authorized Guardian signature:_____ **Date:**_____

STATEMENT OF FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for all bills incurred under the care of Dr Derkasch *regardless of insurance coverage*. I further understand that a finance/billing charge will be added to any overdue balances. **I understand that Dr. Derkasch reserve the right to charge a fee for a broken appointment or an appointment cancelled without 48 hours advance notice.**

By signing below, you acknowledge that you understand the above statement and agree to the terms listed therein:

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RETAIN THIS COPY FOR YOUR RECORDS

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Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, Discover, American Express, Optima, and Care Credit. We will be happy to help you process your insurance claim form for your reimbursement. In most cases, we are able to file your claim electronically, which does not require a claim form. In the instances that we are unable to do so, we require that you bring a completed insurance form at the time of the visit. In special instances we may accept assignment of insurance benefits; however, deductibles and estimated copayments must be paid at the time of service. ***Balances' remaining after each insurance claim is settled are due immediately***. You will be billed for any amounts sent to your insurance carrier if not settled within 60 days.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.33% per month (16% APR), or a minimum billing charge of $1.00. Balances older than 90 days will be turned over to Collection Services, and will be subject to legal action. A $50 charge may also be made for broken appointments and appointments cancelled without 48 hours advance notice. In addition we reserve the right to change or refuse credit terms at any time.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance company (Employer Dental Benefit Program) is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR". "UCR" is defined as usual, customary, and reasonable fees for this region. Thus, our fees are considered usual, customary, and reasonable by most companies.
   This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
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