Kathleen A. Kasper D.D.S. P.A.
1514 East Belt Line Rd. Suite 100
Carrollton, Texas 75006
P: 972-446-0101 Fax 972-446-0052
Email: ourteam@kathleenkasperdds.com
www.kathleenkasperdds.com

Patient Information

Date:_____

Patient Name:_____ Birth Date: _____SS#:_____

Name preferred to be called: _____ If Child, Parent Name_____

Circle One: **Single** **Married** **Divorced** **Separated** **Widowed** **Gender: Male** **Female**

Home Address:_____City_____State_____Zip Code_____

Home Phone #: _____ Cell Phone #:_____

Work Phone#:_____ Email Address: _____

Emergency Contact: _____Relationship: _____Phone #: _____

Referral Information

Name of Person Referring you to our Practice:_____

Employment Information

Employment: Full Time Part Time Retired Not Working

Occupation:_____ Employer's Name: _____

Employers Address: _____Main Phone #:_____

Dental Insurance Information

Ignore the next 4 (four) lines if insured is same as patient

1. Name of Insured:_____ Birth Date: _____ Insured SS#:_____

2. Insured's Address:_____ Phone Number #:_____

3.Insured's Employer Name: _____ Address:_____

4.Work#: _____ Patient relationship to insured: Self Spouse Child Other: _____

Financially Responsible Party: Circle One Patient Insured Parent Other:_____

Insurance Company Name:_____ Address:_____

Phone #:_____Group # :_____ID#: _____

Dental and Health Information

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs both safely and effectively. Incorrect information can be dangerous to your health. Your answers are for our records and will remain CONFIDENTIAL. We appreciate your assistance.

Name of your last Dentist:_____
Date of last visit to dentist:_____Reason:_____
Date of Last dental x rays taken: _____ How Many? _____
Do you have any of your x rays or dental records? _____

In respect to previous dental treatment, have you ever...

Fainted? Yes/No If yes, please explain _____
Experienced difficulty achieving anesthesia? Yes/No _____
Experienced a complication or illness during or following dental treatment? Yes/ No _____
Had an unfavorable dental experience? Yes/No _____
Had complications from an extraction? Yes/No _____
Do you prefer Nitrous Oxide (Laughing Gas) for dental work? Yes / No
Have your teeth shifted, flared, or do you have spaces between your teeth where there were none before? Yes/No _____
Are some of your teeth becoming loose? Yes/No _____
Are you satisfied with the appearance of your teeth? Yes/No_____
Are you interested in whitening your teeth? Yes/ No_____)_____
What brings you to our office? _____

Yes	No	Have you had or do you currently have…
		Have you ever been told you have periodontal (gum) disease?
		Have you ever received periodontal treatment? If yes, describe
		Bleeding gums?
		Unpleasant taste? If yes, describe
		Bad Breath?
		Mouth breathing?
		Have you ever been diagnosed with TMJ/TMD?
		Do you clench or grind your teeth?
		Do you have sore jaw muscles/teeth in the morning, afternoon or all the time?
		Do you wear an appliance (mouthpiece/guard) for clenching or grinding?
		Do you wear an orthotic device for TMJ/TMD?
		Do you get frequent headaches? If yes, how often?
		Do you get migraines?
		Do you have pain and/or clicking of jaws?
		Do you have pain around your ears?
		Sores in your mouth? If yes, how often?
		Frequent blisters on lips or mouth? If yes, how often?
		Swelling or lump in the mouth and/or head and neck area?
		Burning tongue or mouth?
		Finger nail biting, cheek biting or other oral habits?
		Altered Taste? If yes, describe
		Difficulty swallowing?
		Do you brush regularly? How often?
		What is the texture of your toothbrush? Soft – Medium- Hard
		Do you use an electric/power tooth brush? What Type?
		Do you use dental floss? How often?
		Do you use interdental cleaning aids other than floss? Which one(s)?
		Use water jet/pik device?
		Use disclosing tablets or solution?
		Use fluoride supplements or any type of dental rinses?
		Have you had orthodontic treatment (braces). If yes, when where they removed?
		Do you have any other dental concern or complaint?
		Do you have hay fever or sinus problems? Do you take any medication for it?
		Smoke cigarettes /e-cigarettes/ cigars / or a pipe? How much per day? How many years?
		Use smokeless chewing tobacco, snuff or dip?
		Emphysema?
		Difficulty breathing? If yes, describe
		Asthma? If yes, what type?
		Do you use an inhaler? If yes, how often?
		Did you bring your inhaler with you today? What is the name of your inhaler?
		What triggers your asthma attack?
		Ever had an attack that did not stop?
		Other lung problems or disease(s)? If yes, describe

Yes	NO	Have you had or do you currently have
		Blood disorders/disease? If yes, explain
		Excessive bleeding from a cut /surgery/ dental extraction? If yes, explain
		Blood transfusion(s)? Date(s)?
		Have you been diagnosed with a communicable disease (i.e., Sexually Transmitted Disease (STD's), HIV, HIV positive, Tuberculosis, or West Nile virus? If yes, explain
		Anemia/ Anemic?
		High or low blood pressure?
		Chest pain or/and Angina? Do you use Nitroglycerin to control chest pain? Do you carry it with you?
		Do you take blood thinners? (i.e., aspirin, Coumadin, Warfarin)
		Heart surgery? Dates…
		Heart attack? Dates…
		Stints /Bypass Surgery? Dates… If yes, explain
		Heart murmur? If yes, explain
		Irregular heart beat? If yes, explain
		Have you ever had a seizure or convulsion? If yes, explain
		If you have seizures, what is your aura?
		What type of seizure do you have?
		Is your aura always the same before a seizure?
		Have you ever had a seizure that would not stop?
		Have you ever been hospitalized due to a seizure? If yes, explain
		How long do your seizures last?
		Have you ever had a stroke? Dates…
		Problems with your immune system? If yes, explain
		Thyroid problems? If yes, describe
		Diabetes? Which type? When were you diagnosed?
		If you have Diabetes, do you take insulin? How often?
		Kidney trouble?
		Dialysis? When?
		Jaundice, Hepatitis or Liver Disease? If yes, describe
		Irritable Bowel Syndrome (IBS), Ulcerative Colitis or any other Gastrointestinal problem(s)? If yes, explain
		Gall bladder trouble? If yes, describe
		Tumors, Growths, Cancers? If yes, describe
		Chemotherapy, Radiation Treatment? If yes, When?
		Implant or other body prosthesis? If yes, Where?
		Have you been told by your physician that you need an antibiotic before any dental treatment? If yes, explain
		Have you been admitted to a hospital or needed emergency care during the past two years? If yes, explain
		Are you currently under the care of a physician? If yes, explain
		What is your Physician's Name and Phone Number?
		Have you been advised by your physician to stay away from any Medical Device? If yes, explain
		Are you taking or have you taken any medication for Osteoporosis? If yes, write down the name of the medication(s)
		Are you currently being treated for depression or any other psychiatric condition? If yes, explain
		Do you have a history of drug or alcohol addiction? If yes, explain
		Do you use recreational drugs?

Yes	NO	Have you had or do you currently have
		Do you have any other medical condition or health problem not listed on this form that requires further clarification? If yes, explain.
		Are you allergic to any medication? If yes, explain what kind of reaction you had/have?
		Are you allergic to any Local Anesthetic used in dentistry? If yes, please describe what kind of reaction you had /have.
		Please list any Medications that you are currently taking and explain the reason why you are taking each one
		1.
		2.
		3.
		4.
		5.
		6.
		Are you taking birth Control? If yes, please write the name of the medication
		Are you pregnant or do you think you might be pregnant? If yes, please write down how far along you are in your pregnancy and the name and phone number of your OB/GYN (Gynecologist)
		Do you or a family member snore?
		Do you or a family member gasp/choke during sleep?
		Do you use C-pap? Do you know there is an alternative?

Please write down the name, phone number, and address of your preferred pharmacy:

I certify that the information given is correct, and I give consent to receive clinical services:

_____ _____

Patients Signature / Parent or guardian if a minor **Date**

Doctors Notes: **Blood Pressure:**_____ **Pulse:**_____

Kathleen Kasper D.D.S.
1514 East Belt Line Rd. Suite 100
Carrollton, TX 75006
972-446-0101

In an effort to increase efficiency, reduce confusion and keep our fees from rising dramatically, the following financial policy is now in effect for this office. All fees are due and payable at the time of service unless prior arrangements have been made.

Late Cancellation, No show, Late Appt and Failed Appointment

Please call at least 24 hours in advance to change, cancel or reschedule an appointment. We understand there may be an occasional conflict, but we have reserved this time for YOU, please reserve it for US.
A **$50** No Show or Late Cancellation Fee will be charged for failure to cancel each appointment with less than **24** hrs notice, or failure to keep a dental appointment. If you are more than **15** minutes late we will reschedule you for another day and a **$50** dollar fee will be charged. If you fail **3** consecutive appointments, you must confirm your next appointment **24** hours in advance, or this appointment will be allocated to someone else.
After 3 failed appointments or cancellations without notice, we reserve the right to dismiss you as a patient_____ (Initials)

Returned Check Policy

There will be a **$55** fee for all returned checks. A payment must be made there after with a valid credit card or cash _____ (patient Initials)

Patients with Insurance

We prefer that you pay the full fee for the treatment rendered (and you file your own insurance), however, insurance assignments will be accepted with the following provisions:
1. We must be able to verify insurance coverage and benefits prior to your appointment
2. You must provide us with a copy of your dental insurance card.
3. If we have made several attempts **(2)** to file your insurance claim and we can not obtain payment for the claim and/or it's been more than **60** days since the claim was first filed, you are responsible for all charges incurred. You will be responsible for making the appropriate arrangements and disputes with your insurance carrier. A $10 late fee will be added for every month that your balance is outstanding, and after 90 days you will be sent to collections, at which time collection fees will be applied and added to your final bill. _____ (Patient Initials)

Insurance Assignments

In consideration of services rendered or to be rendered, I hereby assign, transfer, and direct Dr. Kasper any insurance benefits payable to me. I agree to cooperate, aid and assist Dr. Kasper in procuring all possible benefits, including initiation and fulfillment of all policy provisions, as such insurance companies may require for payment. _____ (Patient Initials)

Financial Responsibility

I understand, that regardless of my assigned insurance benefits, I am responsible all fees for services rendered including my balance remaining after insurance benefits are paid. I agree to pay all fees, not covered by my insurance, within **30** days unless I have made some financial arrangement. I also understand that if I become delinquent on my account for more than 60 days I will be sent to a collection agency and I will be responsible for all collection and attorney fees that go along with such action. _____ (Patient Initials)

Patient Release Form

I authorize Dr. Kasper to release my medical or dental information to my insurance company, as it may be required for the payment of claims for services rendered or pretreatment estimates. _____ (Patient Initials)

A copy of this financial policy shall have the same validity as the original.
I have read the above policies; I understand them and agree to abide by these provisions.

Responsible Party_____ **Date**_____

Witness_____**Date**_____

Kathleen Kasper D.D.S., .PA.
1514 East Belt Line Rd. Suite 100
Carrollton, Texas 75006

AKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Dr. Kasper's Notice of Privacy Practices.
I authorize the release of my dental records, account history, account ledger, appointment times, and /or my account balances, to the following people:

1._____

2. _____

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement or 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)
- Patient revoked consent

Kathleen A. Kasper D.D.S., P.A.
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ **Email:** _____

Social Security Number: _____

Section B: To the Patient---Please Read the following statement carefully.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of privacy practices: You have the right to read our notice of privacy practices before you decide weather to sign this consent. Our notice describes a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice of privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
Your may obtain a copy of our notice of privacy practices, including any revision of our notice, at any time by contacting:

Contact Person: **Kathleen Ann Kasper**
Telephone: **972-446-0101** **Fax: 972-446-0052**
Email: **exfiles11@aol.com**
Address: **1514 East Belt Line Rd. Suite 100, Carrollton, Texas 75006**

I _____, have had full opportunity to read and consider the contents of this consent form and your notice of privacy practices. I understand that, by signing this consent form, I am giving my consent to use and disclose of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ **Date:** _____

If this consent is sign by a personal representative on behalf of the patient, complete the following:

Personal Representative's name: _____

Relationship to Patient: _____

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation will not affect any action in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Revocation of Consent

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation, I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature: _____ **Date:** _____