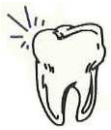
WELCOME TO ADVANCED DENTISTRY
Robert Sorokolit D.D.S.



Patient Information

Patient Name : _____ Today's date: _____/_____/_____
Last Name First Name MI

Preferred name: _____ Birthdate: _____/_____/_____

Social Security # : _____ Age: _____ Sex : ☐ Male ☐ Female

e-mail : _____

Preferred appointment times: ☐ Any Time ☐ Morning ☐ Afternoon ☐ Any day ☐M ☐T ☐W ☐T ☐F

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Sinus Problems
☐ Arthritis	☐ Dizziness	☐ High Blood Pressure	☐ Stomach Problems
☐ Artificial Joints	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Excessive Bleeding	☐ Liver Disease	☐ Thyroid problems
☐ Blood Disease	☐ Fainting	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Cancer	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Chemical Dependency	☐ Head Injuries	☐ Radiation Treatment	☐ Ulcers
☐ Current pregnancy	☐ Heart attack/ Stroke	☐ Respiratory Problems	☐ OTHER:
Due date : _____/_____	☐ Heart surgery/Pacemaker	☐ Rheumatic Fever	_____
	☐ Heart Murmur	☐ Rheumatism	_____

If none of these apply, please write **"NONE APPLY"** _____

Are you allergic to any of the following?

☐ Aspirin	☐ Dental anesthetics	☐ Penicillin / amoxicillin	☐ Tetracycline
☐ Codeine	☐ Latex	☐ Sulfa	

☐ Other Drug allergies: _____

If none of these apply, please write **"NKDA"** (no known drug allergies) _____

Are you currently taking any medications? ☐Yes ☐No

If yes, please list: _____

Medical History

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever taken the drugs Phen-phen or Redux? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____/_____/_____
Signature of patient, parent or guardian

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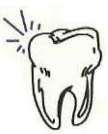

Dental History

- Reason for today's visit:_____
- Date of Last Dental Visit: _____/_____
- Previous Dentist Name : _____

Address: _____
City State Phone Number

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

- Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know
- How would you rate your smile (worst) 1 à 10 (best) _____

Phone Numbers

Phone (Home): _____ (Work) :_____ (Cell/Other): _____

Preferred first call number: ☐ Home ☐ Work ☐ Cell/other (Spouse's work): _____

In case of emergency, who should be notified?

Name : _____ Relationship : _____

Home Phone: _____ Cell phone: _____

Employment Information

Employer Name: _____ Occupation : _____

Address:_____
Street City State Zip Code

Dental Insurance Information

PRIMARY DENTAL INSURANCE

Name of Insured: _____
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name:_____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name:_____

Address: _____
Street City State Zip Code

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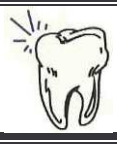

SECONDARY DENTAL INSURANCE (If applicable)

Name of Insured: _____
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name:_____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name:_____

Address: _____
Street City State Zip Code

Referral Information

• Whom may we thank for referring you to our practice? _____

Authorizations

I authorize Advanced Dentistry to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize Advanced Dentistry to perform any and all forms of treatment, medications, and therapy that may be indicated. I herby authorize the release of my dental records to Insurance Carriers or Referred Doctors.

I understand that radiographs and/or photographs maybe taken of my teeth and used by the Doctor as examples of procedures performed to be shown to other patients, displayed in the office and/or used for advertisement. I understand that no likeness of my face nor any readily distinguishable features other than a close-up of my teeth will be used by the doctor for any reason without a separate written prior authorization by me.

I have read, understand, and agree to the above policies.

Signature : _____ Date : _____/_____/_____

I hereby authorize my insurance company to pay directly to the office of Dr. Robert M. Sorokolit, benefits due to me out of the indemnity under the terms of my policy.

Signature : _____ Date : _____/_____/_____

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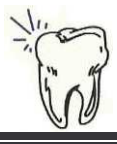

Billing Policy

First and foremost, we want to express our appreciation to you for selecting our practice. It is our privilege to serve you, and we want your experience with us to be as pleasant as possible as we strive to

fulfill your dental needs. The following represents an explanation of our office policies and guidelines concerning financial responsibility.

Please remember your insurance policy is a contract between you and the insurance company/employer, not the doctor. For the convenience of our patients, we will submit all claims of treatment. We will provide an **estimate** of what your insurance will cover for services from information that we receive over the phone, however, we are in no way responsible, nor ever guarantee payment from any insurance provider. We do not render services on the basis that the insurance company will pay any fees. Remember, necessary treatment should be determined by the doctor and patient together, not dictated by "what the insurance company will pay".

A billing statement will be sent to you specifying any insurance payments (if applicable) and your total balance. It is important that you not let your account go past due. In the event your account becomes more than 60 days past due, we will employ outside services to assist in collections and at that time, a 30% finance charge will be added to the total bill. We will make every effort to alert you to the status of your account prior to sending it to collections, and are always willing to find an amicable solution to any problem.

All checks returned by the bank as "NSF" or "insufficient funds" or "account closed", will be charged with a $28.00 processing fee and we do require the check to be replaced by cash, Money order, Visa or MasterCard. If the check is not replaced within ten (10) business days, after being notified, appropriate action will be taken to collect these funds.

We accept cash, personal checks, MasterCard, Visa and most debit cards.

Once you have made an appointment with us, that time is reserved for you. We kindly request that in the event you need to alter your scheduled appointment time, you provide us with not less than 48 hours advanced notice. It is our office policy that once a patient has broken more than one confirmed appointment, that a fee of $50.00 be assessed to each subsequent hour of broken appointments.

Signature : _____ Date : _____/_____/_____

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Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices. Containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations and I understand that you are not required to agree by requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize Advanced Dentistry to leave messages at my home, mobile or work telephone concerning confirmation of my appointments or requesting a call concerning my dental needs.

Patient Name: ________________ Date:___________

Signature: __________________

Relationship to Patient: ____________

Dependent family members also covered by this acknowledgement:

_ _

For office use only:

We were unable to obtain the patients written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other