HUDZINSKI
DENTAL & ASSOCIATES

Patient History

Patient Information (Complete ALL Sections!)	
Full Name	Gender
Street Address Apt #	Date of Birth
City State Zip	Age
Please Circle best DAYTIME phone number to reach you Home Number ( ) - Cell Number ( ) - Work Number ( ) -	Email (For Appointment Reminders)
Occupation	Employer
If you are a student, are you part time or full time student?	Name of College Currently Attending

Spouse/Guardian/Emergency Contact (Complete ALL Sections!)	
Full Name	Gender
Street Address Apt #	Date of Birth
City State Zip	Age
Please Circle best DAYTIME phone number to reach you Home Number ( ) - Cell Number ( ) - Work Number ( ) -	What is this person's relationship to you?
Occupation	Employer

Dental Coverage Information (Complete ALL Sections!)	Dual Coverage Information (For patients who have two dental plans.)
Insurance Company Name	Insurance Company Name
Insured's Name (Person who carries the dental coverage)	Insured's Name (Person who carries the dental coverage)
Insured's ID Number (Cannot process claims without this. May be SSN)	Insured's ID Number (Cannot process claims without this. May be SSN)
Group Number	Group Number
Insurance Company Phone Number	Insurance Company Phone Number

Appointment History (Complete ALL Sections!)	Periodontal History (Indicate Yes or No for each)	Dental History (Indicate Yes or No for each)
When were you last at the dentist?	Do you regularly use dental floss?	Are you aware of any current dental problems?
When were your last dental x-rays?	Do your gums bleed when you brush or floss?	Do you grind or clench your teeth?
Name of previous dentist?	Have you had any periodontal (gum) disease?	Do you wear dentures or partials?
Have you ever worn Braces?	Do you snore or have sleep apnea?	Are your teeth sensitive to heat, cold, or pressure?

How did you hear about us?

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Medical History

Medical History (Circle Y or N if you currently or have had any of the following conditions in the past.)

Y N Heart Disease or Attack	Y N Drug Addiction	Y N Taken alendronate (Fosamax®), or risedronate (Actonel®)?
Y N Angina Pectoris	Y N Alcoholism	
Y N High Blood Pressure	Y N Hemophilia	
Y N Heart Murmur	Y N Epilepsy/Seizures	Y N Being treated or treated in the past with intravenous bisphosphonates (Aredia®,Fosamax®,or Zometa®) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?
Y N Rheumatic Fever	Y N Glaucoma	
Y N Congenital Heart Lesions	Y N Venereal Disease	
Y N Mitral Valve Prolapse	Y N Cancer	
Y N Heart Pacemaker	Y N Chemotherapy	
Y N Heart Surgery	Y N Radiation Therapy	
Y N Artificial Joint (Hip, Knee)	Y N Emphysema	Y N Latex Allergy
Y N Anemia	Y N Tuberculosis	Y N Do you smoke? Y N NA Ready to quit?
Y N Stroke	Y N Asthma	
Y N Kidney Disease	Y N Sinus Pain/Drainage	Y N Currently under the care of a physician?
Y N Stomach Ulcers	Y N Diabetes	Name of physician:
Y N Hepatitis A (Infectious)	Y N Thyroid Disease	
Y N Hepatitis B (Serum)	Y N Arthritis	
Y N AIDS/HIV Positive	Y N Cortisone Treatment	Physician Location:
Y N Liver Disease	Y N Psychiatric Treatments	
Y N Blood Transfusion	Y N Sickle Cell Disease	
Y N Yellow Jaundice	Y N Sleep Apnea	Physician phone number:

Y N Do you have any disease or problem not listed above? If so, please explain:	Y N Female patients: Are you pregnant? If so, how many weeks?
Y N Are you allergic to any medications If so, please list:	Y N Do you use GLP-1 Glucagon-Like Peptide-1 medication?
Please list your medications:	

Consent for Treatment

I hereby certify that all above patient, medical, and dental information is correct and authorize Dr. Hudzinski, Dr. Fryer and staff to take x-rays, study models, photographs, or any other diagnostic aids seemed appropriate by Dr. Hudzinski or Dr. Fryer to make a thorough diagnosis of my dental needs. I authorize Dr. Hudzinski or Dr. Fryer to perform any and all kinds of treatment, medication, and therapy that may be indicated. If any conditions are discovered in the course of treatment which, in the opinion of the doctor require additional procedures or procedures different than those described, I also authorize the performance of these procedures. I also understand that the use of anesthetic agents embodies a certain risk.

I understand that my dental insurance is a contract between me and the insurance carrier and NOT between the Doctor and that I am still fully responsible for all dental needs. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance payments to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred.

I hereby state that I have read and understand this consent, and that all questions about the procedures have been answered to my satisfaction. I consent for Hudzinski Dental & Associates to send dental claims on my behalf (if applicable) and that the claim payment be sent to this office.

Signature of Patient/Guardian_____Date_____Signature of Dentist_____Date_____

Health Summary (Office Use Only)

NKDA	ASA	I	II	III	IV
y/o	M	F			
Overnight hospital stays or surgeries?					

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Patient Objective Checklist

It is very important to us that we take care of your specific needs.
Please check either YES or NO to the things that pertain to you.

Possible Patient Concern	Yes	No
I have not been to a dentist in a long time and I'm worried about what you will tell me about my oral hygiene.		
I am embarrassed with the way my teeth look.		
I would like to see pictures and videos that will help me understand my dental problems		
I have had a bad dental experience and have a lot of fear which has kept me from getting the dental care I need.		
I am interested in achieving and maintaining good oral health.		
I greatly fear going to the dentist.		
I am interested in having a dental cleaning today.		
I have a toothache and that is my biggest concern today.		
I would like to replace my silver fillings with tooth colored fillings.		
I am interested in a smile makeover.		
I want to know more about teeth whitening.		
I want to know more about straightening my teeth.		
I snore or someone has told me I snore.		
I currently wear a CPAP, but find it uncomfortable and want an alternative device.		
I suffer from migraines and want to know how the dentist can give me migraine relief.		
I am interested in learning about financing options so that I may be able to spread my payments out over time.		
I do not have dental insurance and would like to know more about the Office Dental Plan that Hudzinski Dental & Associates offers.		

Additional Patient Comments/Concerns
Please add anything else you feel we should know in order to best serve you and your individualized needs.

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Warranty/Missed Reservation Policy

Our Warranty to You

At Hudzinski Dental & Associates, we pride ourselves on providing optimal dental health to all of our patients and their families. We stand behind our work, which is why we are happy to provide to you a 5 year warranty on a variety of services, something few other offices offer.

Our Part
If our sealants, composite fillings, veneers, inlays, onlays, bridges, or crowns need replacement within 5 years, and the tooth is still restorable, we will replace the restoration of the same type, at no cost to you! All that we ask is you do your part in maintaining optimal dental health.

Your Part
If you brush and floss in the morning and in the evening daily, come to our office for your regular 6-month check-up, and complete all the recommended treatment at our office, you can prevent most or all disease. You must been seen at least twice a year (at our office) for a check-up to consider our warranty in effect.

I have read the above warranty

Patient (or Guardian) Signature_____ Date_____

Missed Dental Reservation Policy

At Hudzinski Dental & Associates, we pride ourselves on being prepared and ready for our patients. We kindly ask the same from you! If you ever need to reschedule a dental reservation with our office, there are many ways to reach our office-you can call us at 440-585-4200, email us at mhudzinskidmd@gmail.com, text us at 440-585-4200, or stop in.

If you are unable to make an appointment, we ask for a 48 hour notice to avoid a $50 fee.

I have read the above policy

Patient (or Guardian) Signature_____ Date_____

Authorization and Consent to Use and Disclose Medical Information

The Medical Privacy Notice of Hudzinski Dental & Associates provides information about how we may use and disclose confidential medical information about you. You have the right to read our Notice before signing this consent. The terms of our Notice may change from time to time. If changed, we would inform you at your next visit.

By signing this Authorization, you agree to let us use and disclose confidential medical information about you for treatment, payment, and dental office operations. This includes information about your dental health and medical health. You are also consenting to the release of health information about you to your insurer, third party, or other agents needed to get payment for your treatment.

I have read the above policy

Patient (or Guardian) Signature_____ Date_____

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HIPAA Policy

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy as a patient. Implementation of HIPAA requirements officially began on April 14, 2003. While we have found these policies for years there have been a few updates that we wanted you to be aware of. This is a shortened version of the HIPAA policy. The full policy is available for your review in the reception area. There are rules and right restrictions on who may see or be notified of your protected health information (PHI). These restrictions do not include the normal exchange of information within our office. HIPAA provide certain rights and protections to you as a patient. We follow these guidelines and provide you with the quality care you deserve. Additional information is available from the US Department of Health and Human Services. You can find them online at www.HHS.gov.

This summarizes our policy here at Hudzinski Dental & Associates.

Patient information will be kept confidential except when it is necessary to provide services or to ensure that all administrative matters related to your care handled properly. This may include, but not limited to, the sharing of information with other healthcare providers, laboratories, and health insurance companies. Patient information (treatment plans, insurance forms, EOB's etc.) may be stored in file cabinets not accessible by patients. Preparing for and during your dental visit such records maybe left, at least temporarily, in administrative areas such as the front office, doctor's desk, 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.

We send out reminders to our patients we do this by one or more of the following: email, calling and sending postcards. We try to make every effort to remind you of your appointment and any treatment that you need. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative we may also send out newsletter or special promotions that we are offering.

Please initial each of the following.

By providing your contact information (phone numbers, home address, email etc) on any of our office forms, you agree to let us use that information to contact you. _____

You agree to us sending electronic e-referrals to specialists, which include your PHI information and x-rays if needed. We also sent electronically to your dental insurance which include submitting protected health information to receive payment for services provided. _____

You give us permission to remind you to take pre-medication prior to appointments if applicable. _____

You give us permission to call in any prescriptions you may need and share your protected health information with the pharmacist. _____

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to protected health information but must agree to abide by the confidentiality rules of HIPAA. _____

You understand and agree to inspections at the office and review of documents which may include protected health information by government agencies or insurance payers a normal performance of their duties. _____

You agreed to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor and I understand you have the right to file a complaint we can help you with this and you will not be penalized for filing a complaint. _____

Your confidential information will not be used for the purposes of marketing or advertising of products goods or services without your permission. _____

We agree to provide patient with access to the records in accordance with state and federal laws we may update this policy is needed to better serve the needs of our patients and practice. _____

By signing below I agree that I have been offered the HIPAA policy and understanding of knowledge my agreement to the terms set forth in the HIPAA information and consent forms and any future updates to this policy.

Print Name:_____Signature:_____Date:_____