Emil W. Tetzner, D.M.D., M.S.
Practice Limited to Periodontics

***Please complete both sides**
AND MAIL BACK TO OUR OFFICE*

Name____ Date____
Street____ Employer____
City & State _________________ Zip Code__________ Occupation____
Home Phone__________________________________ Social Security Number__________________________
Business Phone________________________________ General Dentist ________________________________
Cell____ Referred By__________________________________
E-Mail ______________________________________ Physician_____________________________________
Birth Date ______________________M____F______ Marital Status__________________________________
Height________________ Weight_________________ Spouse or Parent's Name_________________________
Emergency Contact______________________________ Spouse or Parent's Occupation_____________________
Emergency Contact phone _______________________ Dental Insurance ______________________________

MEDICAL HISTORY

Note to patient: These questions are for your benefit. This information will assist us in your diagnosis and treatment. Please check any of the following that apply to you:

____Heart trouble	____Diabetes	____Tuberculosis	____Congenital Heart trouble
____Jaundice	____Kidney Disease	____Heart Murmur\Echo	____Hepatitis
____Arthritis	____Heart Surgery	____Cancer	____Stomach Ulcers
____Rheumatic Fever	____Glaucoma	____Stroke	____Cardiac Pacemaker
____Sinus Trouble	____Epilepsy	____Persistent Cough	____Heart Valve Prosthesis
____Psychiatric Care	____High Blood Pressure	____Asthma	____Child Births
____HIV infection	____Low Blood Pressure	____Blood Transfusion	____Thyroid Disorder
____Joint replacement	____Alcohol/Drug addiction	____High Cholesterol	____Sexually Transmitted Diseases

1. Have you had a recent physical examination___ When? ____________ Lab Work ____When?________
2. Has there been any change in your general health in the last year? ________________________________
   Explain____
3. Have you been under a doctor's care, been hospitalized or seriously ill during the past two years? ___ Explain: ____
4. Do you take any medications or drugs, including aspirin, vitamins, hormones, antacids, steroids or birth control pills presently or within the last six months? Please list below.

DRUG	**DOSE & FREQUENCY**
________________________	____
________________________	____
________________________	____

5. Are you allergic to or have you experienced an unusual reaction to drugs? ____________________________
   Please list? ____
6. Have you experienced any other allergic reactions? Please list: _______________________________
7. Have you experienced excessive bleeding that required special treatment? ________________________
8. Have you ever pre-medicated for a dental appointment? ___________**Do you pre-medicate now**?________________
   Explain: ____
9. Is there a history of diabetes in your immediate family? ____
10. Are you required to restrict your diet, work or activities in any way? ___________________________
11. Do you smoke cigarettes? __________ Cigars? _________ Pipe? _________ How many per day? _________
    For how long? ____
12. Have you ever been treated for a growth or tumor in any part of your body? _____________________
    Explain: ____
13. Are you under a great deal of stress on a daily basis, or has your daily stress increased?
    Explain? ____

14. Do you have frequent headaches? ________________________Migraines? _______________________________
    What area of the head? _______________________________Duration? __________________________________
15. Do you have any disease, condition or problem that you feel we should know about? _______________
    If yes, explain: ____

Women:

16. Are you pregnant? _______Due date? ________Is your menstrual cycle regular? _______________
17. Have you reached menopause? ____
18. Are you having any menopause symptoms? ________________Please list: ____________________

DENTAL HEALTH HISTORY

Check any of the following which you may have had or experienced:

______Injury to face or jaw
______Slow-healing mouth sores
______Fever Blisters
______Mouth Ulcers
______Swollen gums
______Sensitive to Hot
______Sensitive to Cold
______Mouth Odor
______Bad taste in mouth
______Loose teeth
______Aches in Jaw Joint
______Clicking/Popping in Jaw
______Jaw locking-open or closed
______Change in bite
______Tired or sore muscles
______Clench or grind teeth

Which of the following do you do on a daily basis?

Times Brush a day__________ (Soft/Medium/Hard Bristles)

Times Floss a day ___________ Mouthwash (what type)____________________ how often______?

1. If you are currently experiencing pain in your mouth, where is it located? ___________________________________
2. How did it come to your attention that you have a periodontal problem? _____________________________________
3. Do you feel strongly about keeping your teeth for the rest of your life? ______________________________________
4. Are you happy with the appearance of your teeth? ____
5. Have you had orthodontic therapy (braces)? ________________Type? ________________When? _______________
6. Have you had previous periodontal (gum) treatment? _________Type? _______________When? ________________
7. Have you had oral surgery? ____________Type? ________________________________When? ________________
8. Have you had crown and/or bridgework? _________________When? _______________________________________
9. Have you ever worn a bite plane or night guard? _______________________________When? __________________
10. Have you ever noticed a change in the position of your teeth? __________Explain? ___________________________
11. Do you have any difficulty in chewing? __________Explain? ____
12. Is it difficult to open your mouth wide? ____
13. Are you worried about receiving dental treatment? ____
    If so, what is your main concern? ____

Present dentist: ____How long? _______________
Last Dental treatment: ________________________________Type of treatment? ________________________________
Last Cleaning: _____________________________________ Last x-rays: ___________________________________
Pattern of Dental care: ______regular (every ____ months) _______sporadic ______infrequent

Signature____Date______________________

Please complete both sides

Practice Limited to Periodontics

NEW PATIENT INFORMATION FORM

Last Name: ________________________ First: ________________ Middle: ____________
Preferred Name: ____________________________ Title: ___________________________
Home Address: ____
____

Home Phone: _________________Work Phone: __________________ Sex: F___ M___
DOB: ___________________ SS#: _____-_____-______ Marital Status: ______________
Employer Name and Address: ____
____

Referring Dr: _____________________ Referring Patient: ___________________________
Medical Alerts: ____

PRIMARY DENTAL COVERAGE

Subscriber Name and Address: ____
____

Relationship to Patient: ___________________ SS#: ____-_____-______DOB: ____________
Employer Name and Address: ____
____

Insurance Company Name and Address: ____
____

ID#: _____________________ Group#: ________________

SECONDARY DENTAL COVERAGE

Subscriber Name and Address: ____
____

Relationship to Patient: ___________________ SS#: _____-____-_____ DOB: _____________
Employer Name and Address: ____
____

Insurance Company Name and Address: ____
____

ID#: ________________________ Group#: ______________________

RESPONSIBLE PARTY FOR PATIENT

You are responsible for the bill regardless if your insurance covers any of the treatment provided. Payment is expected when services are rendered unless prior arrangements have been made.

Signature: ____ Date: _______________

[*]Emil W. Tetzner, DMD, MS, PA
Specializing in Periodontics and Implantology

OFFICE POLICY

DENTAL INSURANCE AND FINANCIAL ARRANGEMENTS

1. Patients are responsible for fees incurred
2. **Patient payment, for the first visit, is due at the time of service ($165.00)**,
   Insurance will be filed if applicable and adjustments made to the account when and if payment is received from insurance
3. For treatment requiring several visits, estimate of proposed services can be sent to insurance, so that financial arrangements can be made ahead of time[i]
4. **If we do not participate with your insurance** – you are responsible for any amount the insurance does not pay
5. As a courtesy to you, we will submit insurance forms for patients. Please note there are certain insurances who pay the patient directly, in which case, payment is due from the patient the day services are incurred
6. For the remainder of patients with insurance a down payment of 20-50% is required at the time of service. Unlike medical insurance, most dental plans do not cover 100% of charges incurred so after insurance pays the claim we will bill you for any difference due
7. Unpaid balances over 90 days will incur a monthly handling charge of 1.5% monthly (18% A.P.R.)
8. **We accept checks, cash, Master Card, Visa and Discover**
9. In-house no interest short-term financing is available to those who qualify
10. We accept CareCredit for balances over $1000 - 14.99% interest (24 to 48 months)
    balances over $2500 - 14.99% interest (60 months)

BROKEN APPOINTMENTS

The patient must notify this office **24 hours prior to the scheduled appointment time**. We reserve the right to charge a $70.00 fee for a broken appointment with less than 24 hours notice. A **surgical appointment cancelled without 48 hours notice will be charged a $125.00 fee.** We do understand emergencies and illness occur and are taken into consideration. **We reserve the right to cancel appointments if you cannot be reached because of disconnected phone, if we are unable to leave a message, and you do not contact the office. Please inform us of any changes in your contact information.**

Please be advised that for liability reasons we are unable to have children accompany you in the room while procedures are being completed. Please make arrangements for children to be left at home. If you arrive with your child, your appointment will need to be rescheduled.

Please do not hesitate to ask us any questions regarding our office policies. We want you to be comfortable in dealing with these matters and we urge you to contact us if you have any questions regarding these issues.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE OFFICE POLICIES.

Patient's/Parent's Signature ________________________ Date ___________________

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[i] Pre-determinations to insurance are done upon patient request

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[*] updated 4/20/15

(Emil W. Tetzner, DMD MS)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

____

(Please Print Patient's 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)

____

____

____