

Emil W. Tetzner, D.M.D., M.S.

Practice Limited to Periodontics

**\$200.00 fee collected at New Patient appointment.**

**\* Please complete both sides \***

Phone: 302-744-9900

Email: xray@emiltetzner.com

Name \_\_\_\_\_  
Street \_\_\_\_\_  
City & State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Business Phone \_\_\_\_\_  
Cell \_\_\_\_\_  
E-Mail \_\_\_\_\_  
Birth Date \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_  
Emergency Contact \_\_\_\_\_  
Emergency Contact phone \_\_\_\_\_  
Relationship to Emergency Contact \_\_\_\_\_

Date \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
General Dentist \_\_\_\_\_  
Referred By \_\_\_\_\_  
Physician \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Spouse or Parent's Name \_\_\_\_\_  
Dental Insurance \_\_\_\_\_  
Pharmacy Name \_\_\_\_\_  
Pharmacy Phone Number \_\_\_\_\_

### 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:**

_____ Dementia	_____ Joint Replacement	Date/Area of Replacement _____	
_____ Alzheimer's	_____ Cancer	Date/Type of Cancer _____	
_____ Stomach Ulcers	_____ Kidney Disease	_____ Diabetes-A1C _____ FBG _____	_____ Heart Trouble
_____ Jaundice	_____ Osteoporosis	_____ Persistent Cough	_____ Congenital Heart Disease
_____ Arthritis	_____ Glaucoma	_____ Hepatitis	_____ Pacemaker
_____ Rheumatic Fever	_____ Epilepsy	_____ Asthma	_____ Heart Valve Prosthesis
_____ Sinus Trouble	_____ High Blood Pressure	_____ Blood Transfusions	_____ Stroke
_____ Psychiatric Care	_____ Low Blood Pressure	_____ STD/STI	_____ Heart Surgery
_____ HIV infection	_____ High Cholesterol	_____ Child Births	_____ Heart Murmur/Echo
_____ Alcohol/Drug addiction	_____ Tuberculosis	_____ Thyroid Disease	_____ Facial Plastic Surgery/Filler

1. Have you had a recent physical examination and 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: \_\_\_\_\_

**PLEASE LIST ALL MEDICATIONS INCLUDING OTC, VITAMINS AND SUPPLEMENTS:**

DRUG	DOSE & FREQUENCY	DRUG	DOSE & FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Are you allergic to or have you experienced an unusual reaction to drugs? \_\_\_\_\_  
Please list? \_\_\_\_\_
5. Have you experienced any other allergic reactions? Please list: \_\_\_\_\_
6. Have you experienced excessive bleeding that required special treatment? \_\_\_\_\_
7. Have you ever pre-medicated for a dental appointment? \_\_\_\_\_ Do you pre-medicate now? \_\_\_\_\_  
Explain: \_\_\_\_\_
8. Is there a history of diabetes in your immediate family? \_\_\_\_\_
9. Are you required to restrict your diet, work or activities in any way? \_\_\_\_\_
10. Do you smoke cigarettes? \_\_\_\_\_ Cigars? \_\_\_\_\_ Vape? \_\_\_\_\_ Pipe? \_\_\_\_\_  
How many per day? \_\_\_\_\_ For how long? \_\_\_\_\_
11. Have you ever been treated for a growth or tumor in any part of your body? \_\_\_\_\_  
Explain: \_\_\_\_\_

12. Are you under a great deal of stress on a daily basis, or has your daily stress increased?

Explain? \_\_\_\_\_

13. Do you have frequent headaches? \_\_\_\_\_ Migraines? \_\_\_\_\_

What area of the head? \_\_\_\_\_ Duration? \_\_\_\_\_

14. Do you have any disease, condition or problem that you feel we should know about? \_\_\_\_\_

If yes, explain: \_\_\_\_\_

### Women:

15. Are you pregnant? \_\_\_\_\_ Due date? \_\_\_\_\_ Is your menstrual cycle regular? \_\_\_\_\_

16. Have you reached menopause? \_\_\_\_\_

17. Are you having any menopause symptoms? \_\_\_\_\_ Please list: \_\_\_\_\_

### DENTAL HEALTH HISTORY

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

\_\_\_\_\_ Injury to face or jaw

\_\_\_\_\_ Sensitive to Hot

\_\_\_\_\_ Aches in Jaw Joint

\_\_\_\_\_ Slow-healing mouth sores

\_\_\_\_\_ Sensitive to Cold

\_\_\_\_\_ Clicking/Popping in Jaw

\_\_\_\_\_ Fever Blisters

\_\_\_\_\_ Mouth Odor

\_\_\_\_\_ Jaw locking-open or closed

\_\_\_\_\_ Mouth Ulcers

\_\_\_\_\_ Bad taste in mouth

\_\_\_\_\_ Change in bite

\_\_\_\_\_ Swollen gums

\_\_\_\_\_ Loose teeth

\_\_\_\_\_ Tired or sore muscles

\_\_\_\_\_ Clench or grind teeth

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

\_\_\_\_\_ Toothbrush \_\_\_\_\_ Dental Floss \_\_\_\_\_ Stimulents \_\_\_\_\_ Toothpicks \_\_\_\_\_ End-Tuft Brush

\_\_\_\_\_ Fluoride rinse \_\_\_\_\_ Mouthwash (what type) \_\_\_\_\_ \_\_\_\_\_ Proxabrush \_\_\_\_\_ other

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 \****

Emil W Tetzner, DMD, MS  
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:** \_\_\_\_\_

**Insurance Company Claims Address:** \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Phone#: \_\_\_\_\_

**SECONDARY DENTAL COVERAGE**

Subscriber Name and Address: \_\_\_\_\_  
\_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_  
Employer Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Insurance Company Name and Address: \_\_\_\_\_  
\_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Phone#: \_\_\_\_\_

**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 (\$200.00 PLUS ANY ADDITIONAL FEES ASSOCIATED WITH ANY DIAGNOSTIC IMAGING, IF NEEDED).**  
Insurance will be filed if applicable and adjustments will be made to the account when and if payment is received from insurance.
3. **Upon request a pre-determination will be sent to your insurance company. We do not automatically send a pre-determination.**  
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. **WE ARE NOT IN NETWORK WITH ANY INSURANCE COMPANIES. WE ARE AN OUT OF NETWORK PROVIDER. DELTA DENTAL PATIENTS WILL BE RESPONSIBLE FOR 100% OF THE FEES AT THE TIME OF SERVICE. DELTA DENTAL WILL PAY THE PATIENT DIRECTLY.**
4. For the remainder of patients with insurance other than delta, a down payment of 20-75% (dependent upon the procedure and insurance coverage) 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.
5. After treatment is completed any credit balances will be refunded.
6. Unpaid balances over 90 days will incur a monthly handling charge of 1.5% monthly (18% A.P.R.)
7. **We accept CHECK, CASH, MASTER CARD, VISA, DISCOVER AND CARE CREDIT**

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 \_\_\_\_\_

(Emil W. Tetzner, DMD MS)  
**ACKNOWLEDGEMENT OF RECEIPT OF**  
**\* Please complete both sides \***

**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)

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**For Office Use Only**

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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)

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**Emil W. Tetzner, DMD, MS, PA**

**PLEASE READ AND SIGN**  
***APPOINTMENT POLICY AND CANCELLATION FEES***

When you schedule an appointment, we reserve that time just for you. We work very hard to stay on schedule, so it is critical that you arrive on time.

**If you are more than 15 minutes late for an appointment you will need to be rescheduled.**

**If you need to cancel or reschedule your appointment, we require a 24-hour notice. There will be a \$70 broken appointment fee if you are unable to keep your appointment without giving us 24-hour prior notice.**

**If you need to cancel or reschedule your 2-hour surgical appointment, we require 48 hours notice. There will be a \$200 broken appointment fee if you are unable to keep your appointment without giving us 48 hours notice.**

**We do understand emergencies and illness occur and are taken into consideration.**

**I understand and agree to the appointment policy and cancellation fees**

**Name (Please print)** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_

**Directions to Dover office:**

804 S. State Street; Dover, DE 19901  
Phone: 744-9900

**From the South---**

Rt. 1 North to exit 95 to Rt. 10W (toward Camden). Follow Highway 10 West for approximately 2 miles. Turn **RIGHT** on State Street (Alternate Highway 113), cross Highway 13, go thru one light, on left side of street at Gooden, turn left the entrance to our office is off Gooden Ave. **OR** take alternate Highway 13 thru Magnolia, this turns into State Street, Cross Highway 13 thru one light, look for Gooden Avenue on the left.

**From the North---**

Rt. 1 South to exit 97 to Rt. 13 North, left lane, next left is State Street.  
804 S. State Street is two blocks from RT 13. (go thru one light, the next left will be Gooden Ave.) to turn onto Gooden Ave.

**Directions to the Rehoboth Office:**

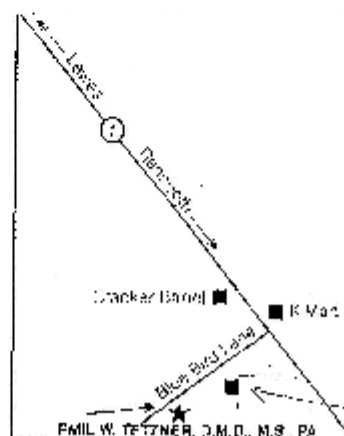
19613 Blue Bird Lane, Suite 2; Rehoboth, DE  
Phone: 302-227-3257

**From the North---**

Rt. 1 south to Rehoboth Beach. Turn right at building with the blue tin roof (Crab House) Restaurant onto Blue Bird Lane---this is the first right turn after the Cracker Barrel Restaurant. Blue Bird Lane is also directly across Rt. 1 from the K-Mart store. Follow Blue Bird Lane approx. 400 ft. to Century Plaza on the left. The office is located in Suite #1. Parking is available in front of the building.

**From the South**

Rt. 1 north to Rehoboth Beach. Turn left at the traffic light at the K-Mart store to proceed south on Rt. 1. Turn right at building with a blue tin roof (Crab House) restaurant onto Blue Bird Lane --- this is the first right turn after the Cracker Barrel restaurant. Follow Blue Bird Lane approx. 400 ft. to Century Plaza on the left. The office is located in Suite #1. Parking is available in the front of the building.

**DOVER OFFICE****REHOBOTH OFFICE**

(EMIL W. TETZNER, DMD MS)

# NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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## **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/15/2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the change. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you via US mail or electronic mail.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described above.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, as assist in the notification of (including identifying or locating) a family member, your personal representative or another