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 Name & Phone number_____

MEDICAL HISTORY

NAME AND PHONE NUMBER OF PHARMACY:_____

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	_____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?

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. Pre-determination are done upon request
7. 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
8. Unpaid balances over 90 days will incur a monthly handling charge of 1.5% monthly (18% A.P.R.)

9. **We accept checks, cash, Master Card, Visa and Discover**

10. We accept **CARECREDIT** for balances:
    Up to $900.00 at 0% interest
    Over $900 - $2499 14.99% interest (24 to 48 months)
    Over $2500 14.99% interest (60 months)

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 _____

[*] updated 4/20/15

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

(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)

Emil W. Tetzner, DMD, MS, PA

OUR APPOINTMENT GUIDELINES

When you schedule an appointment, we reserve that time just for you with our dental staff and doctor. We are committed to honoring the appointment time of our scheduled patients, so it is critical that you confirm your appointment within 24 hours of your appointment and that you arrive on time.

We require verbal confirmation of your appointment, please call the office to confirm your appointment. If you do not confirm your appointment we can only assume you are not coming to the appointment and we will remove you from the schedule.

1) You will receive a post card reminder two weeks prior to your appointment. Feel free to call us and confirm your appointment at that time.

2) Three days prior to our appointment you will receive a confirmation call asking you to return our call to confirm your appointment.

3) If your appointment is not confirmed 2 days prior to your appointment we will make another attempt to confirm your appointment. If you have not confirmed your appointment at least 1 day prior to your appointment we will assume you are not coming and we will have to give your appointment to another patient.

We will cancel your appointment 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.

We understand that circumstances occur that do not allow you to keep your scheduled appointment. In this case, please call us at least 48 hours in advance of your appointment time to reschedule your appointment.

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If you are more than 10 minutes late for an appointment, you will need to be rescheduled.
If you miss your appointment without cancelation, you will not be rescheduled.

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.

Patient Signature _____ Date _____