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

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

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 _____
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:**

____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 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: _____
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?

_____Toothbrush _____Dental Floss _____Stimudents _____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 ($182.00)**
   Insurance will be filed if applicable and adjustments will be 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
4. 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
5. 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.
6. After treatment is completed any credit balances will be refunded.
7. Unpaid balances over 90 days will incur a monthly handling charge of 1.5% monthly (18% A.P.R.)
8. **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
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

PLEASE READ AND SIGN
APPOINTMENT POLICY AND CANCELLATION FEES

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 7 days before your appointment and that you arrive on time.

We require verbal confirmation of your appointment, please call the office to confirm your appointment.

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

2) 1 week 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 7 days prior to your appointment date we will make another attempt to confirm your appointment via phone, if you have a cell phone, we will try to text you.

Without 7 days of notice prior to your scheduled appointment there is a $70.00 fee for Cancelling your appointment or Rescheduling your appointment

If you do not come to your scheduled appointment there will be a $70.00 missed appointment charge, after 3 missed appointments we cannot reschedule you.

We will cancel your appointment if you cannot be reached because of a disconnected phone. Please inform us of any changes in your contact information.

If you are more than 10 minutes late for an appointment, you will need to be rescheduled.

*****A surgical appointment cancelled without 2 weeks notice Will BE CHARGED a $200.00 fee*****

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

Name (Please print) _____

Patient Signature _____ Date _____

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 of 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.

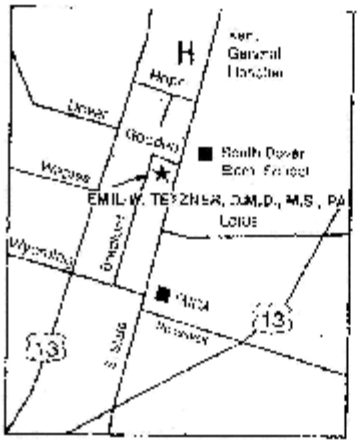
From the North---
Rt. 1 South to exit 97 to Rt. 13 North, left lane, next left is State Street.
804 S. State Street is two blocks from RT 13. (go thru one light, the nex. left will be Gooden Ave), left turn onto Gooden Ave.

Directions to the Rehoboth Office: 19613 Blue Bird Lane, Suite 1; Rehoboth, DE
Phone: 302-227-2257

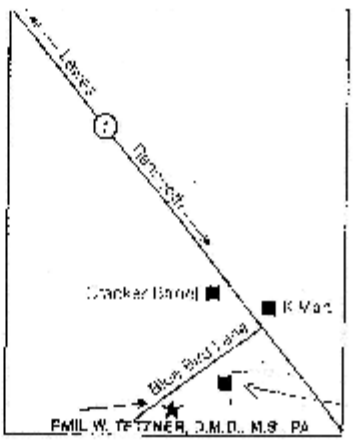
From the North: ---
Rt 1 south to Rehoboth Beach. Turn right at building with the blue tin roof (Crab House) Restaurant onto Blue Bird Lane---this is the first right turn after the Cracker Barrel Restaurant. Blue Bird Lane is also directly across Rt. 1 from the K-Mart store. Follow Blue Bird Lane approx. 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

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.

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.

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 you 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