

# Mitchell S. Katz DDS & Associates

111 Simsbury Road, Avon, CT 06001 | Phone: 860-678-1700

## PATIENT INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First M  Married  Single  Minor  Male  Female  
Address \_\_\_\_\_  
Street Apt # City State Zip  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_  
Telephone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Phone \_\_\_\_\_  
If Full-time Student, School Name \_\_\_\_\_

## REFERRAL INFORMATION

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_  
Name of person or office referring you to our practice \_\_\_\_\_

## INSURANCE INFORMATION

Primary  
Name of Insured \_\_\_\_\_ Is insured a patient?  Yes  No  
Insured's Birth Date \_\_\_\_\_ SS# \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Address \_\_\_\_\_  
Street Apt # City State Zip  
Insured's Employer's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip  
Patient's relationship to insured:  Self  Spouse  Child  Other  
Insurance Plan Name and Address \_\_\_\_\_

## AUTHORIZATION (All Patients or Guardians must sign)

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or credit information. I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

\_\_\_\_\_  
Patient's or Guardian's Signature Date \_\_\_\_\_

# MEDICAL HISTORY

Are you under a physician's care now? Why? Who? \_\_\_\_\_ Phone \_\_\_\_\_ Yes No  
 Have you ever been hospitalized or had a major operation? Discuss \_\_\_\_\_ Yes No  
 Have you ever had a serious injury to your head or neck? Discuss \_\_\_\_\_ Yes No  
 Are you taking any medications, pills or drugs? What? \_\_\_\_\_ Yes No  
 Are you allergic to any medications or substances? Please check box below  
 Aspirin     Penicillin     Codeine     Acrylic     Metal     Latex Rubber     Other  
 Women (Please check):  Pregnant/trying to get pregnant     Nursing     Taking oral contraceptives Discuss Yes No

\* If yes to any of the starred conditions, please call prior to your appointment...Premedication may be required

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (bleeding problem)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur*	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery*	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joint	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Treatments (Radiation)	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone/Steroid Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint*	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant*	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Pollen/Dust)	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>						

Have you ever had any illness not checked above? Yes \_\_\_ No \_\_\_ Discuss \_\_\_\_\_  
 Do you smoke? Yes \_\_\_ No \_\_\_ How many packs / day? \_\_\_\_\_  
 Do you use any other form of tobacco? Yes \_\_\_ No \_\_\_ What kind? \_\_\_\_\_  
 Number of sodas or sweet drinks per day? \_\_\_\_\_  
 Do you wish to talk to the dentist privately about any problems? Yes \_\_\_ No \_\_\_ Discuss \_\_\_\_\_  
 To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

**X** \_\_\_\_\_ Date \_\_\_\_\_  
Patient Signature  
 Reviewed by Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_

# DENTAL HISTORY

Are any family members current patients? Yes No  
 Name of previous dentist \_\_\_\_\_  
 Date of last dental visit \_\_\_\_\_  
 How long since last cleaning? \_\_\_\_\_  
 Reason for changing \_\_\_\_\_  
 Describe your current dental problem \_\_\_\_\_

## APPREHENSION

Do you experience fear of having dental treatment performed? Yes No  
 Anything specific? \_\_\_\_\_  
 Do you dread the numbing after effects? Yes No  
 Have you had any unpleasant dental experiences? Yes No  
 Have you ever received laughing gas in a dental office? Yes No  
 Have you ever received any other kind of sedation for treatment? Yes No  
 Do you feel you need any help overcoming fear? Yes No

## TEETH PROBLEMS

Are your teeth sensitive to hot, cold, sweets or pressure? Yes No  
 Does food regularly wedge between certain teeth? Yes No  
 Do you have any areas that are hard to floss? Yes No

## YOUR SMILE

Do you think you have a pretty smile? Yes No  
 Are your teeth crooked? Yes No If so, does this bother you? Yes No  
 Have you had any cosmetic dentistry? Yes No  
 Do you have any fillings or blemishes on your teeth that look bad? Yes No  
 Would you like to have whiter teeth? Yes No  
 Is there anything that you feel could make your smile look better?  
 \_\_\_\_\_

## HEADACHES AND FACIAL PAIN

Do you have frequent headaches? Yes No  
 Do you experience popping or clicking upon opening or closing? Yes No  
 Do your jaw or facial muscles ever get tired or sore after chewing, sleeping, stress, etc? Yes No  
 Do you experience facial muscle pain while chewing or when you wake up? Yes No

## GUM PROBLEMS

Do your gums ever bleed when you brush or floss? Yes No  
 Have your gums receded or pulled away from your teeth? Yes No  
 Do you have bad breath or bad tastes? Yes No

# HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**The patient understands that:**

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

**This Consent was signed by:** \_\_\_\_\_  
Printed Name-Patient or Representative

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature Date  
Relationship to Patient  
(if other than patient)

\_\_\_\_\_  
**Witness:**  
\_\_\_\_\_  
Printed Name-Practice Representative

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature Date

**Mitchell S. Katz, D.D.S. and Associates  
111 Simsbury Road  
Avon, CT. 06001**

**Mitchell S. Katz, DDS & Associates**  
**Office Financial Policy and Assignment of Benefits**

We would like our patients to be informed of our financial policy. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

**Payment is due at the time service is rendered.** . Our practice accepts cash, personal checks, Mastercard, Visa, American Express and Discover.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 45 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring proof of insurance at each appointment

Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. The following provisions identify our policies governing insurance claims:

1. We cannot provide services on the assumption the charges will be paid by an insurance company. We diagnose and recommend treatment based on what is necessary and in the best interest for our patients to optimize their oral health. We can only estimate your expected benefit payment, not guarantee it. Should your plan pay less than expected, you are fully responsible for the balance.
2. We require you to pay the **estimated** co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. The co-payment is only an estimate of charges and may be found to be insufficient after review by your insurance company
3. Our fees are generally considered to fall within the acceptable range (UCR) by most insurance companies. Some insurance companies pay a fixed allowance for certain procedures, and others pay a percentage of the charge. The benefits available to you are dictated by the policy purchased for you by your employer.
4. Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. If your claim is denied, you will be responsible for paying the full amount at that time.
5. Insurance payments ordinarily are received within 30-45 days from the time of billing. If your insurance company has not made payment to our practice within 45 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
6. Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or

questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice

7. Please update our office coordinators regarding any changes to your dental insurance, so that your claim can be processed in a timely manner.
8. If your son or daughter is enrolled in college you must provide proof of enrollment to your insurance carrier. Otherwise claims will be held up indefinitely by your insurance carrier.

**Finance charges**

**Returned checks and balances older than 45 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).**

**Additionally, our practice will charge you for appointments that you do not keep and for appointments that you do not cancel within 48-hours notice.**

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care

**I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.**

\_\_\_\_\_  
Print Name of Patient or Responsible Party

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

***Mitchell S. Katz, D.D.S. & Associates  
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(860) 678-1700***

## ***CREDIT/DEBIT CARD AUTHORIZATION***

*This credit card authorization document gives your approval to pay the balance for services not paid by your insurance carrier.  
I request notification of all charges applied to my card.*

***I, \_\_\_\_\_ hereby give my fully-informed consent, & I agree  
(name as it appears on card)  
to allow Mitchell S. Katz, D.D.S. & Associates to debit my credit/debit card.***

***Card Company Name: \_\_\_\_\_  
(Visa, American Express, Discover, MasterCard)***

***Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_***

***Security Code: \_\_\_\_\_***

***Signed: \_\_\_\_\_***

***Dated: \_\_\_\_\_  
(Signature of cardholder)***

***THIS AUTHORIZATION EXPIRES ON: \_\_\_\_\_***