

# Mary Ziomek, D.D.S., LLC

Chart #: \_\_\_\_\_  
FOR OFFICE USE ONLY

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)  
Gender \_\_\_\_\_ Family Status \_\_\_\_\_ Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Ph: \_\_\_\_\_  
Preferred appointment times:  Morning  Afternoon  Evening  Any Time  M  T  W  T  F  S  
Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Dentist's Name: \_\_\_\_\_  
Reason for this visit: \_\_\_\_\_

### Have you ever had any of the following? Please check those that apply:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> HIV / AIDS         | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Mental Disorders      | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Allergies _____    | <input type="checkbox"/> Growths               | <input type="checkbox"/> Nervous Disorders     | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Head Injuries         | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Pregnancy             | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Heart Murmur          | Due date: _____                                | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease      | or Mitral Valve Prolapse                       | <input type="checkbox"/> Radiation Treatment   | OTHER:                                      |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Premedicated prior to | <input type="checkbox"/> Respiratory Problems  | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Diabetes           | dental treatment                               | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Sinus Problems        |   |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Stomach Problems      |   |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                |   |
| <input type="checkbox"/> Fainting           | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Tooth Implants        |   |

- Are you taking any medication?  Yes  No What? \_\_\_\_\_
- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_  
Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

## Referral Information

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

## Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

## Insurance Information

### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

## Consent for Dental Services

I confirm that I have come to the Dentist to obtain dental services. I consent and authorize examination and treatment as determined to be necessary by the Doctor or by her staff under her supervision.

### Accuracy of Health Information.

I understand that the Doctor and her staff will rely on my answers to the HEALTH INFORMATION questionnaire, and affirm that my answers are true and complete. I agree to hold the Doctor and her staff harmless for any injury which I may suffer as a result of my failure to fully complete the HEALTH INFORMATION questionnaire truthfully and accurately.

### Payment for Dental Services

I understand that I am fully responsible to pay for all services provided to me by the Doctor or her staff under her supervision at the time services are rendered. I understand that any insurance coverage I may have is for my personal benefit and does not release me from my obligation to pay for the services provided to me, at the time they are rendered. I agree that I am responsible to collect whatever benefits may be due from any insurance company. Neither the Doctor nor her staff has this responsibility. I acknowledge that if this office prepares and submits any insurance claim information on my behalf, it is done solely as a courtesy to me, and I agree to allow the Doctor to apply any payments received from my insurance company against any sum that I owe.

**I understand that I may be charged a missed appointment if 24 hour notice is not given before breaking or canceling.**

### Collection of Overdue Accounts

I agree to pay the Doctor interest on my outstanding account at the rate of 1.5% per month, beginning 60 days after services are provided to me. I further agree to pay all attorney fees, court costs, or any other costs of collection if the Doctor incurs any such costs to collect money due on my account.

**I have read and agree to all of the above conditions of treatment and consent to allow you to speak with me at work or at home to discuss my treatment, condition, or account.**

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_