Thank you for choosing Karmazin Dental for your dental needs. We look forward to providing you with the highest quality of dental care.

Attached you will find the new patient paperwork that will need to be filled out and brought with you to your appointment.

Please contact us if you have any questions or concerns regarding your upcoming appointment. Karmazin Dental does uphold a 24 hour cancellation policy, we ask that if you need to cancel your appointment for any reason please call the number below 24 hours in advance.

(605) 323-1320

*If you have been to see another dentist within the past 3 years, we ask that you contact them and request copies of any current x-rays, you may have.

If possible please have them email your current x-rays to: Karmazinreferral@yahoo.com
We look forward to seeing you soon!

-The Staff of Karmazin Dental-

karmazin DENTAL

NEW PATIENT INFORMATION

TODAY'S DATE ____/____/____

PATIENTS NAME:

STREET ADDRESS:

CITY:	STATE:	ZIP:

HOME PHONE:	WORK PHONE:
CELL PHONE:	E-MAIL:

DATE OF BIRTH:	SSN:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:

DO YOU HAVE DENTAL INSURANCE: YES NO

POLICY HOLDER'S NAME:

POLICY HOLDER'S DOB:	POLICY HOLDERS SSN:

NAME OF INSURANCE COMPANY:

NAME OF EMPLOYER INSURANCE IS THROUGH:

EMERGENCY CONTACT INFORMATION:

NAME AND RELATIONSHIP TO PATIENT:

PHONE NUMBER:

PLEASE LIST ANY SPECIFIC QUESTIONS OR AREAS OF CONCERN YOU HAVE ABOUT YOUR ORAL HEALTH :

HOW LONG HAS IT BEEN SINCE YOU WERE SEEN BY A DENTIST?

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

karmazin DENTAL

Health History

Patient Name:			
Are you under a physician's care now?	☐ Yes	☐ No	If yes:
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes:
Are you taking an medications, pills, or drugs?	☐ Yes	☐ No	If yes:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	If yes:
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes:
Are you on a special diet?	☐ Yes	☐ No	If yes:
Do you use tobacco currently?	☐ Yes	☐ No	If yes:
Have you used tobacco in the past?	☐ Yes	☐ No	If yes:
Do you use any other controlled substances?	☐ Yes	☐ No	If yes:
Are you aware, or been told, that you snore?	☐ Yes	☐ No	If yes:
Have you ever had a sleep study?	☐ Yes	☐ No	If yes:
Have you ever been told to wear a CPAP?	☐ Yes	☐ No	If yes:

Women: Are you…

☐ Pregnant/Trying to get pregnant?	☐ Nursing?	☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you have any other know drug allergies? ☐ Yes ☐ No If yes:

Do you have, or have you had, any of the following? (please check all that apply)

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Asthma	☐ Fainting Spells/ Dizzy	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joint	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Venereal Disease

Have you ever had a serious illness not listed above? ☐ Yes ☐ No If yes:

Additional Comments:

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian:

X Date:

The Epworth Sleepiness Scale

Name:________________________________ Date:_______

Your Age (years):______ Your Sex: Male Female

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times.

Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the ***most appropriate*** number for each situation.

0 = would ***never*** dose
1 = ***slight*** chance of dozing
2 = ***moderate*** chance of dozing
3 = ***high*** chance of dozing

Situation	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total	

Thank you for your cooperation!

5701 S Remington Place, Sioux Falls, SD 57108
E: info@karmazindental.com | **W:** karmazindental.com | **P:** 605 323 1320 | **F:** 605 323 1329

FINANCIAL POLICY

This statement is to inform you of our financial policy. We at Karmazin Dental, are committed to providing you with the highest quality of dental care, utilizing only the best materials and education available. In our process of doing so, we have formulated a financial policy to continue excellent service to you and minimize our administrative costs.

Payments are due at the time the service is provided, unless previous arrangements have been set up and agree upon both by you the patient, and us the provider. Our office accepts cash, check, Visa, MasterCard, Discover, and Care Credit.

For those of you with dental insurance, as a courtesy, we will assist you in processing your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing authorization on the Consent for Use and Disclosure of Health Information agreement. In order for our office to file your insurance claim, you must bring your insurance card to each appointment. It is also the responsibility of the patient to inform Karmazin Dental if there have been any changes to their insurance provider or policy. Any co-payment that is the patient's responsibility is due when the service is provided.

All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer, and your insurance company. Our office is not a party to that contract or any possible restrictions.

Returned checks and balances older than sixty days may be subject to collection fees and finance charges at the rate of 1.5% per month (18 % annually). Additionally, it is our policy here, at Karmazin Dental, that if for any reason you are unable to keep a scheduled appointment, it is the responsibility of the patient to notify us at least 24 hours prior to that appointment. If an appointment is cancelled or the patient simply does not show up, we reserve the right to assess a fee on to the patients account. In the event that the missed or broken appointment is for a hygiene cleaning a straight fee of $25.00 will be charged to the account. If the appointment was for treatment (i.e. crowns, fillings, etc. . .) the fee assessed will be 25% of the appointments original estimated cost.

If you have any questions regarding our financial policy, please do not hesitate to ask. We are committed to providing you with the most positive experience in dental care.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY
AND, BY SIGNING, I PERMIT YOU TO SUBMIT MY CLAIMS TO MY INSURANCE COMPANY.

____ ____________

PATIENTS SIGNATURE DATE

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 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
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please specify)

____
____
____