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

To better serve you, we have assembled the following New Patient packet with several important documents that will assist us in making your transition to our office as smooth as possible. Please read and complete each document carefully, and bring the completed forms with you to your scheduled appointment.

Please contact us with any questions or concerns you have regarding your upcoming visit. Karmazin Dental upholds a 24-hour cancellation policy. If you need to cancel your appointment for any reason, please notify us 24-hours in advance by calling (**605) 323-1320**.

Note: If you have been seen by another dentist within the past 3 years, we ask that you contact them and request copies of any current x-rays they may have in your patient records. If possible, please have them email your current x-rays to: Karmazinreferral@yahoo.com

For more information about our practice, philosophy and policies, please visit our website at www.karmazindental.com.

We look forward to serving you soon!

- **The Friendly Staff of Karmazin Dental**

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NEW PATIENT INFORMATION

PATIENT INFORMATION

Today's Date: _____

This appointment is for: ☐ Self ☐ Dependent ☐ Other

Patient's Name: _____ (Last) _____ (First) _____ (M.I.) Prefers to be called by: _____

Social Security No: _____ Date of Birth: _____ Age: _____ Marital Status: _____

Address: _____ _____ (City) _____ (State) _____ (Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

How long has it been since you were last seen by a dentist? _____

Previous Dentist (if applicable): _____ Dentist Phone: _____

Name of Person Responsible for this Account: _____

Whom may we thank for referring you to our office? _____

EMERGENCY CONTACT INFORMATION

In the event of an **emergency**, who should we contact:

Contact Name: _____ Relationship to Patient: _____

Contact Phone: _____ Type: ☐ Home ☐ Work ☐ Cell

INSURANCE INFORMATION

Do you have Dental Insurance? ☐ Yes ☐ No

Policy Holder's Name: _____ Date of Birth: _____ SSN: _____

Name of Insurance Company: _____ Tel #: _____

Group ID: _____ Insurance ID: _____

Name of Employer Insurance is Through: _____

Please list any specific questions or areas of concern you have about your oral health:

_____

_____

_____

_____

_____

_____

_____

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HEALTH HISTORY

Patient Name: _____ **Date:** _____

Are you under a physician's care now?	☐ Y ☐ N	If yes:	
Have you ever been hospitalized or had a major operation?	☐ Y ☐ N	If yes:	
Have you ever had a serious head or neck injury?	☐ Y ☐ N	If yes:	
Are you taking an medications, pills, or drugs?	☐ Y ☐ N	If yes:	
Do you take, or have you taken, Phen-Fen or Redux?	☐ Y ☐ N	If yes:	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Y ☐ N	If yes:	
Are you on a special diet?	☐ Y ☐ N	If yes:	
Do you use tobacco currently?	☐ Y ☐ N	If yes:	
Have you used tobacco in the past?	☐ Y ☐ N	If yes:	
Do you use any other controlled substances?	☐ Y ☐ N	If yes:	
Are you aware, or been told, that you snore?	☐ Y ☐ N	If yes:	
Have you ever had a sleep study?	☐ Y ☐ N	If yes:	
Have you ever been told to wear a CPAP?	☐ Y ☐ N	If yes:	

Women: Are you... ☐ Pregnant/Trying to get pregnant ☐ Nursing? ☐ Taking Oral Contraception

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? ☐ Y ☐ N If yes: _____

Are you allergic to any of the following?

☐ 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? ☐ Y ☐ N 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:

_____ **Patient's Signature** _____ **Date**

The Epworth Sleepiness Scale

Patient Name: _____ **Date:** _____

Your Age (years): _____ Type: ☐ 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.

Scale:

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!

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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.

_____ _____

PATIENT'S SIGNATURE DATE

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

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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):

_____
_____
_____
_____
_____

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