ADA American Dental Association®
America's leading advocate for oral health

Today's Date: _____

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Mailing Address:	City:	State: Zip:
Date of Birth: / /	Gender:	
Occupation:		
Emergency Contact: Name:	Relationship:	Phone:

If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

Please mark an "X" in the box ONLY if this applies to you.

Is it hard to open your mouth? ☐
Does it hurt to chew, bite or swallow? ☐
Do your gums bleed when you brush or floss your teeth? ☐
Have you ever had periodontal (gum) treatments like scaling and root planing? ☐
Do you have, or have you ever had, any sores or growths in your mouth? ☐
Do you clench or grind your teeth? ☐
Does your jaw click, pop or hurt? ☐
Do you have earaches or neck pains? ☐
Does dental treatment make you nervous? ☐
Have you ever experienced any of these sleep-related breathing disorders? ☐
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

Have you ever had a serious injury to your head or mouth? ☐
If yes, please describe what happened and when it happened: _____

Have you ever had problems with dental treatment in the past? ☐
If yes, please describe what happened: _____

Have you ever had a reaction to, or problem with, dental anesthesia? ☐
If yes, please describe what happened: _____

Are you unhappy with your smile? ☐
If yes, why? Please mark all that apply:
☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth
☐ Other. Please describe: _____

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions. Yes No ?

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐
If yes, what medication are you taking? _____
Are you taking any medication to treat **osteoporosis** or Paget's disease? ☐ ☐ ☐
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).
If yes, what medication are you taking? _____
Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).
If yes, what medication are you taking? _____ How many years have you been taking it? _____
Are you taking **hormonal replacements**? ☐ ☐ ☐
Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐
Do you use **vaping products**? ☐ ☐ ☐
How many **alcoholic beverages** do you have per week? _____
Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐
If yes, what substances? _____ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally
Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? _____
Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements?** ☐ ☐ ☐
If yes, please list them here and include information about how much and how often you use each one. _____

WOMEN ONLY: Are you:
Taking **birth control pills**? ☐ ☐ ☐
Pregnant? If yes, number of weeks: _____ ☐ ☐ ☐
Nursing? If yes, number of weeks: _____ ☐ ☐ ☐

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ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes	No	?
Aspirin	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Hay fever/seasonal allergies	☐	☐	☐
Iodine	☐	☐	☐
Latex (rubber)	☐	☐	☐
Local anesthetics	☐	☐	☐
Metals	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐

	Yes	No	?
Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	☐	☐	☐
Other	☐	☐	☐

Please describe any "Yes" answers and include information about your experience.

_____

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

Please use an "X" to mark your answers to the following questions.	Yes	No	?
Are you in good physical health?	☐	☐	☐
Are you currently being seen or treated by a physician?	☐	☐	☐
Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?	☐	☐	☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years?	☐	☐	☐
Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	☐	☐	☐
Have you had a **heart valve replacement or heart surgery**?	☐	☐	☐
Have you had an **organ or bone marrow/stem cell transplant**?	☐	☐	☐
Have you traveled internationally within the last 30 days	☐	☐	☐
Have you had a fever (100.4°F or above) in the last 72 hours?	☐	☐	☐

If you answered yes to any of the above, please explain: _____

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No	?
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator	☐	☐	☐
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Stroke	☐	☐	☐
Breathing (Respiratory) Health			
Asthma (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐

	Yes	No	?
Cancer	☐	☐	☐
Type: _____			
Date of diagnosis: _____			
Chemotherapy: _____			
Radiation treatment: _____			
Blood (Circulatory) Health			
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
High or low blood pressure	☐	☐	☐
Brain (Neurological)/Mental Health			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury or concussion	☐	☐	☐
Autoimmune Disease			
AIDS or HIV Infection	☐	☐	☐
Lupus	☐	☐	☐

	Yes	No	?
Digestive Health			
Gastrointestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn (GERD)	☐	☐	☐
Stomach ulcers	☐	☐	☐
Eye (Vision) Health			
Glaucoma	☐	☐	☐
Other			
Arthritis	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes (type I or II)	☐	☐	☐
Eating disorder	☐	☐	☐
Frequent infections	☐	☐	☐
Type of infection: _____			
Hepatitis, jaundice or liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection (STI)	☐	☐	☐
Thyroid problems	☐	☐	☐

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?
had pain or tightness in the chest?	☐	☐	☐
coughed up blood or had a cough that lasted longer than 3 weeks?	☐	☐	☐
been exposed to anyone with tuberculosis?	☐	☐	☐
had a rapid or irregular heart beat?	☐	☐	☐
found it hard to catch your breath?	☐	☐	☐
had a high fever (greater than 101.5˚F) for no reason?	☐	☐	☐
noticed a change in your vision?	☐	☐	☐
fainted for no reason?	☐	☐	☐
experienced vomiting, diarrhea, chills, night sweats or bleeding?	☐	☐	☐
had migraines or severe headaches?	☐	☐	☐

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.
I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____

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Office Policies of Dr. James G. Kokorelis, D.D.S, PA

Hello! Welcome to our office! As a new Patient, we would like to acquaint you with our standard office policy. Our top priority is to provide quality dental care with a minimum of inconvenience and discomfort to our patients. In order for the office to run smoothly, which benefits both our patients and ourselves, we want to make you aware of our office policy and payment procedures in order to prevent any future misunderstandings.

- **Payment is required on the day of treatment.** We accept cash, personal checks, money orders, Visa, Discover, MasterCard, or American Express. There will be a $25 fee for any returned checks. We offer our senior patients (age 65 and over) a 10% courtesy. We also offer an in house insurance program for those without insurance. Please ask our staff for more information.
- **Those patients who have dental insurance are advised that your policy is a contract between you and the insurance company and that you are responsible for the full amount of the bill that is not payable by your insurance company.** We are glad to file your claim for you as a courtesy and request that you make benefits payable to Parkville Family Dentistry. We also require that any deductibles or co-pays amount are to be paid on the day of treatment. Although we will be able to assist you, we strongly suggest that you make yourself knowledgeable about the coverage, which your insurance provides such as yearly maximums, deductibles etc., as it is not our responsibility to educate you about this information. Our primary objective is to provide high quality dental care at a fair fee. We cannot allow the insurance company to dictate the standard and quality of our care. **We base our treatment recommendation on your dental needs, not what insurance companies allow. If you have questions regarding your insurance benefits, please contact your employer or insurance carrier directly. We <u>estimate</u> your co-pay based on the procedure performed and the information we have on file regarding your benefits. If the insurance does not pay what we estimate, then you are responsible for any additional balance due. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement.**
- **Any accounts which are 90 days past due will be referred for collection.** We do not have a finance charge or late payment charge as long as your bill is paid when due. If you are having a problem meeting your payment obligations we urge you to contact us immediately so that a specific payment arrangement is agreed upon. If no satisfactory arrangement is agreed upon and we find it necessary to turn over an account for collection, that debtor will also be responsible for any collection cost, which may incur.
- Parkville Family Dentistry knows your time is valuable, and we respect that! In fact, we make it a point to schedule all of our patients with this in mind. Our daily goal is to seat all of our patients on time. In an effort to provide timely service to our patients we never over-book our schedule like so many other health care facilities. This makes our time very valuable to us as well. Therefore, in an effort

to avoid broken appointments and late patient arrivals, the following policy has been adopted:

1. All cancellations or rescheduled appointments must be arranged two business days prior to appointment date.

2. Patients arriving more than ten minutes late may be rescheduled at Parkville Family Dentistry's discretion.

3. Patients who...

- don't show up for their appointment, or
- reschedule without two business days' notice

Will be charged a $50.00 missed appointment fee. To avoid raising our dental fees and allow for all of our patients to reserve appointment times when desired, we find it necessary to implement this policy. After three broken appointments, the patient will be scheduled on the same day, or the patient will have to pay for their appointment in advance. Thank you for understanding and respecting our time and policy.

- We allow 45 days from the date that the claim is filed for the insurance company to pay. If the insurance company fails to pay within the time period, you will be responsible for the entire balance.
- You must notify us of any changes in your insurance coverage prior to your visit. If you fail to do so, and the claim needs to be resubmitted, you will be responsible for the full amount of your bill and can be reimbursed by your insurance company.

For treatment that requires a prosthesis, I understand that an additional laboratory fee will be applied.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

I, _____, acknowledge that I have received a notice of privacy practices from Parkville Family Dentistry.

If a personal representative signs this authorization on behalf of the individual receiving treatment, complete the following:

Personal Representative's name:_____

Relationship to individual receiving treatment: _____

The undersigned has read and accepts the above, and agrees to abide by all terms and conditions as stated.

Print name:_____

Signature:_____ Date:_____

General Informed Consent for Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.
It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided:
I understand that during my course of treatment that the following care may be provided: Examinations, Preventive Services, Diagnosis, Basic Restorative and Crowns:

2. Drugs and Medications:
I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. Changes in Treatment Plan:
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary after being informed by the treating doctor and/or other staff.

4. Insurance:
I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

5. Text Messaging:
I give permission to the dental office to receive invoices and statements through texts. Usage and data rates may apply.

Patient Signature: **Date:**

Parkville Family Dentistry

Dr James Kokorelis D.D.S.
Dr Steve Kokorelis D.D.S.
Dr John Henry D.D.S.
Dr. Arjun Vaidyanathan D.D.S.
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Patient Preferred Pharmacy Form

We, at Parkville Family Dentistry, are very pleased that you have chosen us as your primary dental provider. In order to better serve you, your prescriptions will now be electronically processed directly to your pharmacy. Please provide us with your pharmacy information in the space provided below. If you are unable to provide your preferred pharmacy information to us today you may call us back with the information or fax this completed form to the number provided above. If at any time there is a change in your pharmacy information, please provide the updated information to our Front Desk staff.

Patient Name: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

* If you do not have a Preferred Pharmacy please select one of the two below (these are both located on Harford Rd and Joppa Rd)

☐ Walgreens (9616 Harford Rd, Parkville, MD 21234)

☐ CVS (2911 E Joppa Rd, Parkville, MD, 21234)