Name_____Soc. Sec.#_____
Date of birth_____Age_____Sex M F Home phone_____
Address_____
Street city state zip code
Occupation_____Employer_____
Business phone_____
Physician_____Physician's phone #_____
Parent or Guardian_____
Whom may we thank for referring you to our office?_____
EMERGENCY
CONTACT:_____PHONE#_____

MEDICAL HISTORY:
Circle any of the following which you have had or have at present-

HEART CONDITION	LIVER DISEASE
HEART ATTACK OR STROKE	HEPATITIS A (INFECTIOUS)
HEART MURMUR	HEPATITIS B (SERUM)
CHEST PAINS (ANGINA)	YELLOW JAUNDICE
HEART SURGERY	BLOOD TRANSFUSION
ARTIFICIAL HEART VALVE	THYROID DISEASE
HEART PACEMAKER	CORTISONE MEDICINE
HIGH BLOOD PRESSURE	GLAUCOMA
RHEUMATIC FEVER	ARTHRITIS OR RHEUMATISM
ANEMIA OR HEMOPHILIA	PAIN IN JAW JOINTS
BRUISE EASILY	FAINTING OR DIZZY SPELLS
SHORTNESS OF BREATH	ALCOHOLISM
SWELLING OF ANKLES	DRUG ADDICTION
ARTIFICIAL JOINT	CANCER OR TUMOR
LUNG DISEASE	RADIATION THERAPY
EMPHYSEMA	CHEMOTHERAPY(CANCER OR LEUKEMIA)
TUBERCULOSIS (T.B.)	HIV POSITIVE / AIDS
ASTHMA OR HAY FEVER	VENEREAL DISEASE
SKIN RASHES OR HIVES	GENITAL HERPES
KIDNEY TROUBLE	COLD SORES
DIABETES	EPILEPSY or SEIZURES
SICKLE CELL DISEASE	PSYCHIATRIC TREATMENT

Do you have any other diseases, conditions or problems that are not listed above? YES / NO . If yes , please explain_____

Are you presently taking any medicine or drugs?YES / NO . If yes , please explain_____

Are you allergic to any medicine, drug or other substance? YES /NO . If yes, please explain_____

See next page----------→

Are you now or have you been under the care of a medical doctor (other than routine care) during the last two years? YES/ NO. If yes , please explain_____

When was your last physical examination by a physician?_____

Have you ever been hospitalized or had surgery ? YES / NO

Have you ever had a reaction to a local anesthetic? YES / NO

Have you ever had prolonged or unusual bleeding? YES / NO

Have you ever had complications or illness following dental treatment? YES / NO

Do you have any unhealed injuries or inflamed areas in or around your mouth ? YES / NO

Have you experienced any growth or sore spots in your mouth? YES / NO

Does any part of your mouth hurt when clenched? YES / NO

Have you ever had Novocaine anesthetic ? YES / NO

Any reactions or allergic symptoms to Novocaine? YES/ NO

Any difficult extractions in the past? YES / NO

Any prolonged bleeding following extractions in the past? YES / NO

Do your gums bleed ? YES/ NO

Have you ever had instructions on the care of your gums? YES / NO

Have you ever had instruction on the correct method of brushing your teeth ? YES / NO

Do you chew on only one side of your mouth? YES / NO . If yes, why?

Do you at the present time have any dental complaints? YES / NO . If yes, What?_____

Do you habitually clench your teeth during the day or night? YES / NO

When was your last full mouth x-ray taken?_____Where?_____

Is any part of your mouth sore to pressures or irritants such as cold, sweets , etc...? YES /NO . If yes, where?_____

Do you smoke or use smokeless tobacco? YES / NO

Are you nervous or concerned about having dental work done? YES/ NO

WOMEN: Are you pregnant now? YES / NO
If yes, due date_____
Are you practicing birth control? YES / NO
Do you anticipate becoming pregnant?YES / NO
Have you had any complications or problems with a previous pregnancy? YES / NO

DENTAL TREATMENT DESIRED (CIRCLE)

Check up	Teeth cleaning	Cavities restored
Missing teeth replaced	Cosmetic bonding	Teeth extracted
Complete dentures	Orthodontics	Teeth bleaching

Other_____

To the best of my knowledge the preceding answers are true and correct. If I have any changes in my health or medications, I shall inform Dr. Knotek at the next appointment without fail.

_____ _____

Date Signature

FINANCIAL RESPONSIBILITY AGREEMENT

Name of person financially responsible for this account_____
Relationship to patient_____ Phone (___)_____ Cell (___)_____
Address_____ City_____ State___ Zip_____
Name of employer _____ Work Phone (___)_____

Name of closest relative not living with you _____ Phone (___)_____
Address _____ City _____ State ___ Zip_____

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security # _____
Name of employer _____ Work Phone (___)_____

___ I authorize use of this form on all my insurance submissions.
___ I authorize release of information to all my insurance carriers.
___ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
___ I authorize payment directly to my doctor.
___ I permit a copy of this authorization to be used in place of the original.
___ I understand that I am financially responsible for any remaining balances not covered by insurance.
___ I understand that Dr. Knotek is not responsible for any verbal information given by insurance companies; although, she and her representatives strive for accurate information.

Signature_____ Date_____

HAVING NO DENTAL INSURANCE

I elect to pay cash ____, check ____, credit card ____ on all visits as treatment progresses.

The undersigned agrees that all past due amounts beyond 30 days are subject to collections and/or small claims court. The undersigned accepts full responsibility and agrees to notify this office within 10 days of any change of address or phone number. The undersigned assumes and agrees to pay for all collection agency fees paid or incurred by us, collection agency fees can be up to an additional 50% percent of the amount turned over for collection. In the course of collection of the amount due, an attorney may be engaged by this office or by the collection agency to help with the collection. The undersigned agrees to pay reasonable attorney fees, court costs and other costs paid or incurred by this office or our collection agency while collecting the amount due.

Signature_____ Date_____
Relationship to patient_____

GEORGIA KNOTEK, D.D.S. PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowedgement

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

LUMINEERS® BY CERINATE® SMILE EVALUATION

A Simple Quiz to Help You Obtain the Smile You've Always Wanted

NO PAIN—YOU DON'T EVEN NEED AN ASPIRIN.

THE MOST SIGNIFICANT COSMETIC ADVANCEMENT...EVER

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth careful then answer the following questions. If you are not happy with the appearance of your teeth, ask your denti how LUMINEERS can improve your smile.

1 Do you like the appearance of your teeth; your smile? ❑ Yes ❑ No
If not, explain _____

2 Are your teeth all in alignment (straight)? ❑ Yes ❑ No
If not, explain _____

3 Do you have spaces that you don't like? ❑ Yes ❑ No
If yes, explain _____

4 Do you like the color of your teeth? ❑ Yes ❑ No
If not, explain _____

5 Do you like the shape of your teeth? ❑ Yes ❑ No
If not, explain _____

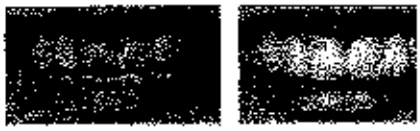
6 Are your teeth...
chipped?_____protruding?_____hidden?_____

7 Are your teeth wearing on the biting surfaces? ❑ Yes ❑ No
If yes, explain _____

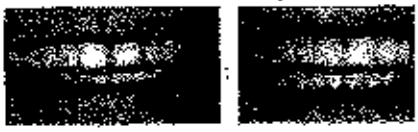
8 Are there old fillings or dental work you don't like looking at? ❑ Yes ❑ No
If yes, explain _____

9 What would you like to change the most in the appearance of your teeth?
_____

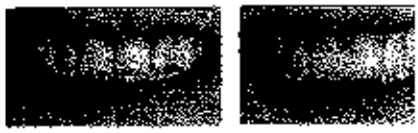
10 How would you like your teeth to look?
_____



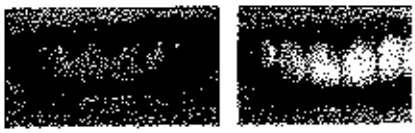
STAINED AND CHIPPED



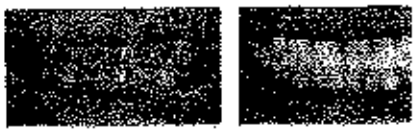
SPACES



CALCIFICATION STAINS



FANGED TEETH



STAINED AND CROOKED TEETH

PORCELAIN CROWNS

BEAUTIFUL SMILE

YOUR SMILE IS THE EASIEST WAY TO IMPROVE YOUR APPEARANCE!

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BY CERINATE®
lumineers.com