

KRISTIAN LUNDGREN-KOSZEGHY, D.M.D., M.M.Sc., Inc.

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Welcome to our office. If you are a new patient, it is important that you know the following:

Our office does not discriminate on the basis of race, sex, sexual orientation, national origin, age or disability.

This office is in compliance with (and in many cases exceeds) the latest state and federal infection control requirements.

The office protects the privacy of all our patients. Documents with sensitive information (like social security numbers or medical records) are shredded when no longer needed.

If you have any questions or concerns about office procedures or policies, please feel free to discuss them with the doctor or any of our staff members.

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this
(Please Print Name)

office's Notice of Privacy Practices.

(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)

PATIENT INFORMATION

Name: _____ Date of Birth: _____ () Male () Female
Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email Address: _____ Social Security #: _____

Please tell us at which number(s) we may leave a detailed message and/or courtesy reminder call:

Please Initial: () Home () Work () Mobile

Who referred you to our office? _____

In Case of Emergency, whom should we contact?

Name: _____ Phone Number: _____ Relationship: _____

PERSON RESPONSIBLE FOR ACCOUNT (IF NOT PATIENT)

Name: _____ Date of Birth: _____ () Male () Female

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Carrier

Insurance Company Name: _____ Group/Plan #: _____

Claims Mailing Address: _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Subscriber ID # or Social Security #: _____ Relationship to Patient _____

Insured's Employer: _____

Secondary Dental Insurance Carrier (if applicable)

Insurance Company Name: _____ Group/Plan #: _____

Claims Mailing Address: _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Subscriber ID # or Social Security #: _____ Relationship to Patient _____

Insured's Employer: _____

Assignment and Release:

I authorize my insurance company(s) to pay Dr. Lundgren-Koszeghy all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the office of Dr. Lundgren-Koszeghy to release all information necessary to secure payment of benefits.

*** I understand that I am financially responsible for all charges whether or not paid by my insurance. ***

Signature: _____

Date: _____

HEALTH QUESTIONNAIRE

Please circle (Y) or (N) to the following questions. Answer ONLY those questions you are certain about.

1. HAVE YOU HAD THE FOLLOWING:

- | | | | | | | |
|-------------------------------|---|-----|----------------------------------|-----|-----|-----|
| Rheumatic Fever | (Y) | (N) | Anemia | (Y) | (N) | |
| Mitral Valve Prolapse (MVP) . | (Y) | (N) | Hepatitis or liver disease | (Y) | (N) | |
| Heart Attack | (Y) | (N) | High Blood Pressure | (Y) | (N) | |
| Brain Injury or Stroke | (Y) | (N) | Radiation Treatment | (Y) | (N) | |
| Arthritis | (Y) | (N) | Bleeding Diseases | (Y) | (N) | |
| Allergies | (Y) | (N) | Glaucoma | (Y) | (N) | |
| Epilepsy | (Y) | (N) | Tumors, Cancer, growths | (Y) | (N) | |
| Asthma | (Y) | (N) | HIV+; & ARC; AIDS | (Y) | (N) | |
| | | | | | | |
| 2 | Date of last physical exam: ____ / ____ / ____ | | | | | |
| 3 | Has there been any change in your general health in the last year?..... | | | | (Y) | (N) |
| 4 | Has the doctor said you have ever had "heart trouble?"..... | | | | (Y) | (N) |
| | If yes, when _____ | | | | | |
| | | | | | | |
| 5 | Has your doctor said you have "stomach ulcers?"..... | | | | (Y) | (N) |
| 6 | Do you have diabetes?..... | | | | (Y) | (N) |
| 7 | Does anyone in your family have diabetes?..... | | | | (Y) | (N) |
| 8 | Did a doctor ever say you have kidney trouble?..... | | | | (Y) | (N) |
| 9 | Do you ever have seizures or convulsions?..... | | | | (Y) | (N) |
| 10 | Do you have frequent, severe headaches or neckaches?..... | | | | (Y) | (N) |
| 11 | Do you have sinus trouble?..... | | | | (Y) | (N) |
| 12 | Have you ever had your teeth ground to adjust the bite?..... | | | | (Y) | (N) |
| 13 | Do you use an occlusal guard? (night guard)..... | | | | (Y) | (N) |
| 14 | Have you ever had Orthodontic treatment to straighten your teeth? | | | | (Y) | (N) |
| 15 | Do you have trouble or discomfort in opening your jaw wide?..... | | | | (Y) | (N) |
| 16 | Do you have any blood disorder?..... | | | | (Y) | (N) |
| 17 | Do you bruise easily?..... | | | | (Y) | (N) |
| 18 | Have you ever had tuberculosis (TB)?..... | | | | (Y) | (N) |
| 19 | Have you ever had a sexually transmitted disease?..... | | | | (Y) | (N) |
| 20 | Have you gained or lost as much as 10 pounds in the last 6 months?..... | | | | (Y) | (N) |
| 21 | Do you experience sounds in the joints of your jaw?..... | | | | (Y) | (N) |
| 22 | Do you suffer from pain or sensitivity of the joints of your jaw?..... | | | | (Y) | (N) |
| 23 | Do you often find yourself clenching and/or grinding your teeth?..... | | | | (Y) | (N) |
| 24 | Do you suffer from pain and/or swelling of your gums?..... | | | | (Y) | (N) |
| 25 | Do your gums often bleed when you brush your teeth?..... | | | | (Y) | (N) |
| 26 | Have you ever had treatment for gum trouble?..... | | | | (Y) | (N) |
| 27 | Do you smoke or chew tobacco?..... | | | | (Y) | (N) |
| 28 | Have you ever had a bad reaction to dental anesthetic?..... | | | | (Y) | (N) |
| 29 | Have you ever had an allergic reaction to latex?..... | | | | (Y) | (N) |

30 Please list any drugs to which you have allergies:

- _____
- _____
- _____
- _____
- _____

31 Have you had any kind of prosthetic device placed such as:..... (Y) (N)

- a heart valve
- an artificial hip
- bone plates
- bone screws
- dental implants
- other: _____

32 Are you presently under treatment for emotional disorders?..... (Y) (N)

33 Have you ever had any serious illness or major surgery not listed above?..... (Y) (N)

If yes, please describe:

34 **MEDICATIONS**

Please list all medications you are presently taking:

- _____
- _____
- _____
- _____
- _____

35 Have you ever used "Phen-fen" or Redux for weight loss/control?..... (Y) (N)

36 Have you ever used Fosamax, Bisphosphonate, or any medication to increase bone density?..... (Y) (N)

37 **FEMALE**: Are you pregnant?..... (Y) (N)

Name of Physician: _____ City: _____

Name of Dentist: _____ City: _____

SIGNED: _____ **DATE:** _____

UPDATES

SIGNED: _____ **DATE:** _____

SIGNED: _____ **DATE:** _____

For Office Use Only			
Doctor Review:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FINANCIAL POLICY

This agreement is to inform you of your financial obligation to our practice. We are committed to providing exceptional periodontal and implant specialty care. Please understand that payment of your bill is considered a part of your treatment. Payment is due in full at the time of service unless **prior** financial arrangements are made.

We offer several payment options:

- Credit cards accepted: Visa, MasterCard and Discover.
- 5% Discount for payments made in full on the day of service with cash or check.
- In office monthly payment plans available at the discretion of the practice.
- Long-term payment plans available through Care Credit.

Please remember that you are responsibly for timely payment of your account. Any balances over 60 days are considered past due. Should it become necessary to refer your account to an agency or attorney for collection, you will be responsible for all costs associated with the collection attorney's fees and court costs.

DENTAL INSURANCE

As a courtesy to you, we will complete and submit claims to your dental insurance on your behalf. We are only in-network providers with Delta Dental, but will also process claims to any other dental carriers. There are hundreds of insurance plans in America. Therefore, it is impossible for our office to know the policies and covered benefits of each and every plan. It is the responsibility of the patient to know and understand the policies and benefits of his or her insurance. It is not our responsibility to debate coverage with your insurance carrier.

In the event your insurance benefits change, it is your responsibility to notify us so that we may update your account. **There is no guarantee of payment from your insurance company, even with pre-authorizations. For such reasons, you, the patient, are 100% responsible for all incurred balances.**

Co-payments, deductibles and estimated patient portions are due the day of service. If pre-authorization from your insurance carrier is not available, 20% of treatment fee is due the day of procedure, and a claim will be filed with your insurance company. Once the claim has been processed, any remaining balance is your responsibility.

We allow your insurance company sixty days after submitting the claim to make payment. After sixty days the patient is responsible for 100% of the account balance. There are some extenuating circumstances that would make the 60-day policy flexible, but each extension would be up to our discretion.

Additional fees might be incurred, regardless of your estimate, if during the course of treatment, additional procedures are deemed necessary by Dr. Lundgren-Koszeghy.

MISSED APPOINTMENT POLICY

Once an appointment has been made, that time is reserved specifically for you. We reserve the right to charge a fee for all cancelled or missed appointments without 24 (business) hours notice. Example, an 8am Monday appointment needs to be cancelled by 8am the previous Friday.

AUTHORIZATION

I authorize Dr. Koszeghy and his designated team to perform a periodontal examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, I authorize the release of any information acquired in the course of my examination and treatment to another doctor or medical team at my request, or as necessary for treatment, planning or referral.

I understand the above policies and agree to terms herein.

Signature

Date