Kevin F. Postol, DDS
FAMILY AND COSMETIC DENTISTRY

WELCOME – TELL US ABOUT YOURSELF

Name: _____
Last *First* *MI* *Title*

Preferred Name: _____ ❒ Male ❒ Female

Address: _____ City: _____ State: _____ ZIP: _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

Employer: _____ Occupation: _____

Marital Status: ❒ Single ❒ Married ❒ Minor ❒ Divorced ❒ Widowed ❒ Separated

How did you hear about our office? _____

Do you prefer to be contacted for appointed confirmation via: ❒ Email ❒ Text ❒ Phone (❒ Home ❒ Cell ❒ Work)

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: Subscriber DOB:_____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Postol, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges weather or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

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DENTAL HISTORY

How may we help you today? _____

Your current dental health is: ❒ Good ❒ Fair ❒ Poor

Do you require antibiotics before dental treatment? ❒ Yes ❒ No

Are you currently in pain? ❒ Yes ❒ No

Have you ever had gum treatment? ❒ Yes ❒ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❒ Yes ❒ No

Are you under stress? (new job, moving, relationships) ❒ Yes ❒ No

Do you wake up with a headache or jaw pain of unknown origin? ❒ Yes ❒ No

Do you like your smile? ❒ Yes ❒ No

Is there anything you would like to change about your smile? ❒ Yes ❒ No

Are you happy with the color of your teeth? ❒ Yes ❒ No

Do your gums bleed? ❒ Yes ❒ No

Do you have a dry mouth? ❒ Yes ❒ No

How many times do you: floss/week? _____ brush/day? _____

Are your teeth sensitive to hot, cold or anything else? ❒ Yes ❒ No

Have you lost any teeth? ❒ Yes ❒ No

Have you ever had a serious/difficult problem with any previous dental work? ❒ Yes ❒ No

Have you ever had any unfavorable dental experiences? ❒ Yes ❒ No

Are you apprehensive about dental care? ❒ Yes ❒ No

Do you prefer Nitrous Oxide (laughing gas) during dental procedures? ❒ Yes ❒ No

Are you interested in relaxation (sedation) dentistry? ❒ Yes ❒ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at Kevin F. Postol, D.D.S. we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Veneers/Lumineers	Sleep Apnea Treatment	Bonding
6 Month Braces	Smile Makeover	Implant Crowns	Sealants
Partials/Dentures	Crown and Bridge	Night/Sport Guards	Invisalign

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MEDICAL HISTORY

Do you have a personal physician? ❒ Yes ❒ No

Physician's Name: _____

Physician's Phone Number: _____

Date of last physician visit: _____

Your current physical health is: ❒ Good ❒ Fair ❒ Poor

Are you currently under the care of a physician? ❒ Yes ❒ No

If yes, please explain: _____

Do you use tobacco in any form? ❒ Yes ❒ No

Are you taking any medications? ❒ Yes ❒ No

Please list each one: _____

Have you ever had any surgical procedures? ❒ Yes ❒ No

Please list each one: _____

Do you snore or have you been told that you do so? ❒ Yes ❒ No

Do you have sleep apnea? ❒ Yes ❒ No

If yes, do you currently wear a CPAP? ❒ Yes ❒ No

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
❒	❒	Abnormal Bleeding	❒	❒	Glaucoma	❒	❒	Shingles
❒	❒	Alcohol/Drug Abuse	❒	❒	HIV+ AIDS	❒	❒	Sickle Cell Disease
❒	❒	Allergies	❒	❒	Heart Attack	❒	❒	Sinus Problems
❒	❒	Anemia	❒	❒	Heart Murmur	❒	❒	Sore/Enlarged Lymph Nodes
❒	❒	Angina Pectoris	❒	❒	Heart Surgery	❒	❒	Stroke
❒	❒	Arthritis	❒	❒	Hemophilia	❒	❒	Thyroid Problems
❒	❒	Artificial Heart Valve	❒	❒	Hepatitis A B C	❒	❒	Tuberculosis
❒	❒	Asthma	❒	❒	High Blood Pressure	❒	❒	Ulcers
❒	❒	Blood Transfusion	❒	❒	Joint Replacement			
❒	❒	Cancer	❒	❒	Kidney Problems			
❒	❒	Chemotherapy	❒	❒	Liver Disease			
❒	❒	Colitis	❒	❒	Mitral Valve Prolapse			
❒	❒	Congenital Heart Defect	❒	❒	Osteoprosis			
❒	❒	Diabetes	❒	❒	Pace Maker			
❒	❒	Difficulty Breathing	❒	❒	Psychiatric Problems			
❒	❒	Emphysema	❒	❒	Radiation Therapy			
❒	❒	Epilepsy	❒	❒	Rheumatic Fever			
❒	❒	Fainting Spells	❒	❒	Seizures Penicillin			
❒	❒	Frequent Headaches	❒	❒	Sexually Transmitted Diseases			

Yes	No	Allergies
❒	❒	Asprin
❒	❒	Codeine
❒	❒	Dental Anesthetics
❒	❒	Jewelry
❒	❒	Latex
❒	❒	Metals
❒	❒	other

Yes	No	If Female, Please Answer
❒	❒	Are you taking Birth Control Pills?
❒	❒	Are you pregnant? If so, # of Weeks _____
❒	❒	Are you Nursing?

Nearest relative not living with you: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

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FINANCIAL POLICY

At **Kevin F. Postol, D.D.S.,** we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you do have dental benefits, you are very fortunate. Here are some important things you should know:

Initial

_____ Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay in full for completion of your dental care. It is only meant to assist you.**

_____ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally hundreds of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have but it is **ONLY AN ESTIMATE.** If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will you a more accurate out of pocket figures you may require.

_____ We will bill your insurance as courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ **Kevin F. Postol, D.D.S.** does require payment in full for your portion at the time services are rendered unless prior payment arrangements have been made. We accept MasterCard, Visa, Discover, cash and checks. If you are in need of an extended finance option: we also work with CareCredit who offer 6,12 or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan on approved credit.

_____ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment we require at **least 24 hour** notice to avoid a **$35/hour cancellation fee** (emergencies are an exception).

_____ In the event of an emergency after regular business hours a **$55 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **$125 after hours emergency fee.**

I agree with the above conditions.

Print Name: _____ Date: _____

Patient/Parent Signature: _____