



**(734) 676-1656**  
**kakarisdentistry.com**  
 21080 Allen Road, Woodhaven

## Patient Questionnaire

What is your major dental complaint?

Date \_\_\_\_\_

MEDICAL HISTORY									
PHYSICIANS NAME			ADDRESS				TELEPHONE		
GENERAL QUESTIONS			Y	N	SPECIFICS				
Are you in good health?									
Are you under medical treatment?									
Are you taking medicine regularly? If so, please list medication.									
Have you been hospitalized within the last 5 years? If so, why?									
Have you ever had excessive bleeding requiring special treatment?									
Are you taking coumadin (blood thinner)?									
Do you have a pacemaker?									
Have you had heart surgery or trouble?									
Have you ever needed to be premedicated for any reason?									
Have you ever been diagnosed or exposed to the AIDS virus?									
DO YOU HAVE/EVER HAD?		Y	N			Y	N		
Heart Murmur				Hepatitis				Jaundice	
High or Low Blood Pressure				Cancer or Tumor Treatment				Stroke	
Diabetes				Rheumatic Fever or Scarlet Fever				Psychiatric Treatment	
Tuberculosis or Lung Disease				Bleeding Problems				VD (Syphilis, Gonorrhea)	
Heart Disease or Lesions				Asthma or Hay Fever				Other	
Epilepsy				Arthritis				Other	
MEDICAL CONDITIONS			Y	N	SPECIFICS				
Do you have any medical conditions that we should know about?									
ARE YOU ALLERGIC TO ANYTHING?		Y	N			Y	N		
Penicillin and Other Antibiotics				Tranquilizers, Sedatives				Fluoride	
Sulfa Drugs				Aspirin				Other	
Local Anesthetics				Iodine				Other	
Barbiturates				Codeine				Other	
WOMEN PLEASE			Y	N	SPECIFICS				
Are you pregnant? If so, when are you due?									
DENTAL HISTORY									
ARE YOU BOTHERED WITH THE FOLLOWING SYMPTOMS?			Y	N	SPECIFICS				
Bleeding Gums									
Tenderness when chewing									
Bad Breath									
Pain in or near the ears									
Popping or clicking of the jaw									
Sensitivity to heat, cold or sweets									
GENERAL QUESTIONS			Y	N	SPECIFICS				
Have you been treated by a Periodontist?									
Have you been treated by an Orthodontist?									
Have you received instructions in the care of your teeth?									
Do you wish to maintain your own teeth and avoid dentures?									
DATE YOU LAST VISITED DENTIST			PURPOSE						

Signature \_\_\_\_\_

Date \_\_\_\_\_



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**Patient Information**

Whom may we thank for referring you to our office?

Date \_\_\_\_\_

PATIENT INFORMATION				
NAME		SOCIAL SECURITY		BIRTH DATE
ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE		CELL PHONE	
E-MAIL ADDRESS	COLLEGE STUDENT (CIRCLE)			SCHOOL NAME
	YES	NO	FULL TIME	PART TIME
EMERGENCY CONTACT			PHONE NUMBER	
SPOUSE'S NAME			BIRTH DATE	
PERSON RESPONSIBLE FOR THIS ACCOUNT				
NAME		RELATIONSHIP	SOCIAL SECURITY	BIRTH DATE
ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE		CELL PHONE	
E-MAIL ADDRESS	DRIVER'S LICENSE		IS THIS PERSON A PATIENT IN OUR OFFICE?	
			YES	NO
PRIMARY INSURANCE				
NAME OF INSURED		SOCIAL SECURITY NUMBER	RELATIONSHIP	BIRTH DATE
HOME PHONE	CELL PHONE		WORK PHONE	
EMPLOYER	ADDRESS			
INSURANCE CARRIER	CONTRACT NUMBER		GROUP NUMBER	
PHONE NUMBER	ADDRESS			
SECONDARY INSURANCE				
NAME OF INSURED		SOCIAL SECURITY NUMBER	RELATIONSHIP	BIRTH DATE
HOME PHONE	CELL PHONE		WORK PHONE	
EMPLOYER	ADDRESS			
INSURANCE CARRIER	CONTRACT NUMBER		GROUP NUMBER	
PHONE NUMBER	ADDRESS			

Signature \_\_\_\_\_ Date \_\_\_\_\_





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**Information Request Form**

Date \_\_\_\_\_

**PATIENT INFORMATION**

NAME			
ADDRESS	CITY	STATE	ZIP CODE
PHONE	E-MAIL ADDRESS		

**REQUESTED INFORMATION OR SERVICE**

PLEASE PRINT YOUR ANSWER BELOW

**OFFICE USE ONLY**

FOLLOW UP	Y	N	DATE
Information Sent by Uproar Communications			
Information Follow Up by Office			



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**Patient Referral Form**

Date \_\_\_\_\_

**PATIENT INFORMATION**

NAME			
ADDRESS	CITY	STATE	ZIP CODE
PHONE	E-MAIL ADDRESS		

**REFERRAL INFORMATION**

NAME (OF REFERRAL)			
ADDRESS	CITY	STATE	ZIP CODE
PHONE	E-MAIL ADDRESS		

**OFFICE USE ONLY**

CONTACT	Y	N	DATE
Contacted by Uproar Communications			
Contacted by Office			



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## Authorization to Bill Insurance Carrier and Agreement to Pay for Services

Date \_\_\_\_\_

I authorize and hereby request my insurance company to pay directly to **Kakar Family Dentistry** and insurance benefits otherwise payable to me.

\_\_\_\_\_ initial

I understand, and agree that **Kakar Family Dentistry** will, as a courtesy, bill my insurance company for services performed in their office. I further understand, that my dental carrier may pay less than the actual bill for services, and I agree to be financially responsible for all of the services performed for:

\_\_\_\_\_ name

I understand, and agree that my insurance benefits are estimates only, based on the information available at the time, and are in no way a guarantee of payment.

\_\_\_\_\_ initial

I understand, and agree that payment in full is expected at each appointment, and my choice of payment options have been explained to me. My preferred method of payment for today's visit will be:

\_\_\_\_\_ cash/check

\_\_\_\_\_ credit card

\_\_\_\_\_ care credit



Signature \_\_\_\_\_

\_\_\_\_\_ Date

I understand, and agree that if any outside collection becomes necessary, I will be responsible for any and all fees incurred in doing so.

I understand, and agree that **Kakar Family Dentistry** has the right to charge me \$40.00 for any appointments that I fail to keep without providing the office with at least a 24 hour notification of cancellation.



Signature \_\_\_\_\_

\_\_\_\_\_ Date



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# Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Date \_\_\_\_\_

I, \_\_\_\_\_, understand that as part of my healthcare, **Kakar Family Dentistry** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among other health professionals who may contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals
- A means with which to assist in our patient communication by providing reminders of upcoming appointments, the need to schedule an appointment, etc. through telephone calls, answering machine messages, and/or postal reminders.

I understand and have been provided with a *Notice of Information Practices (January 2003)* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

I understand that **Kakar Family Dentistry** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **Kakar Family Dentistry** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the code of Federal Regulations. Should **Kakar Family Dentistry** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail). I wish to have the following restrictions to the use or disclosure of my health information: *(Examples – restrictions on: which family members we may communicate with regarding your care, making reminder calls, sending reminder notices, who may approve treatment for minors, etc.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept/decline the terms of this consent.

 Signature \_\_\_\_\_ Date \_\_\_\_\_

## For Office Use Only

- Consent received by \_\_\_\_\_ on \_\_\_\_\_.
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical record on \_\_\_\_\_.



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**Patient Consent to the Use and Disclosure  
of Health Information for Treatment,  
Payment, or Healthcare Operations**

Date \_\_\_\_\_

I, \_\_\_\_\_  
patient's name

\_\_\_\_\_  
address

\_\_\_\_\_  
city, state, zip code

\_\_\_\_\_  
date of birth

hereby authorize:

\_\_\_\_\_  
physician's name

\_\_\_\_\_  
address

\_\_\_\_\_  
city, state, zip code

to release any information in my medical records relating to my  
diagnosis and treatment history for sleep disorders and sleep  
disordered breathing to:

**Kakar Family Dentistry**  
21080 Allen Road  
Woodhaven, MI 48183  
Telephone: (734) 676-1656  
Fax: (734) 362-8662

to assist in the evaluation of my suitability for treatment of  
sleep disordered breathing.

I authorize the release of a full report of examination findings,  
diagnosis, treatment program, etc., to any referring or treating  
physician or dentist. I additionally authorize the release of  
any medical information to insurance companies or for legal  
documentation to process claims.



Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Patient Consent to an Oral Cancer Screening

Date \_\_\_\_\_

Kakaris Family Dentistry strives to give you the best possible care. We recommend an oral cancer screening once (1) a year for non-At-Risk patients and twice (2) a year for "At-Risk patients." The VELscope is a screening tool to help assist in oral cancer screening. It is at a low cost of \$25.00, which we will bill to your insurance; however, they may or may not cover depending on your insurance contract.

**Approximately 25% of oral cancer cases have NO known risk factors.**

**At-Risk Patients** include the following:

- Family history of cancer
- More common in men than women
- More common in African Americans
- Greater risk after age 35
- History of tobacco use (past and/or present)
- Consumption of alcohol
- Substance abuse / Use of recreational drugs
- Eating disorder
- Prolonged exposure to sunlight (lip cancer)
- The sexually transmitted infection Human Papillomavirus (HPV)

YES, I wish to have this done.

NO, I do NOT wish to have this done.

 Print Name \_\_\_\_\_

 Signature \_\_\_\_\_ Date \_\_\_\_\_