



**Life Active Member**  
**American Academy of Periodontology**  
**Specialist in Periodontics**

Dr. Walter J. Kucaba, DDS, MS, PA  
 Periodontics, Dental Implants & Sleep Apnea

PATIENT INFORMATION (Confidential)

Name \_\_\_\_\_ Referral: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address  
 (if different from above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

SS# \_\_\_\_\_ Sex: Male  Female  Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Phone # \_\_\_\_\_

Employer \_\_\_\_\_

MEDICAL HISTORY

List any medications you are currently taking \_\_\_\_\_

Do you take blood thinners daily? YES  NO  Which One?  Aspirin 81mg  Plavix  Warfarin  
 Aspirin 325mg  Coumadin  Other \_\_\_\_\_

List any medications which have caused an ALLERGIC reaction:  Aspirin  Codeine  iodine  Penicillin  Latex  
 Local Anesthetic  Sulfa Drugs  Other \_\_\_\_\_

Do you have to PRE-MEDICATE prior to a dental procedure?  YES  NO What antibiotic? \_\_\_\_\_

Please check all that you have or that you have had in the past:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ANEMIA                             | <input type="checkbox"/> EPILEPSY                | <input type="checkbox"/> MONONUCLEOSIS         |
| <input type="checkbox"/> AIDS / HIV                         | <input type="checkbox"/> HEMOPHILLIA             | <input type="checkbox"/> ORTHODONTIC TREATMENT |
| <input type="checkbox"/> ARTHRITIS, RHEUMATISM              | <input type="checkbox"/> HEPATITIS A             | <input type="checkbox"/> RADIATION TREATMENT   |
| <input type="checkbox"/> ARTIFICIAL JOINTS,<br>WHERE? _____ | <input type="checkbox"/> HEPATITIS B             | WHEN? _____                                    |
| <input type="checkbox"/> ASTHMA                             | <input type="checkbox"/> HEPATITIS C             | <input type="checkbox"/> RHEUMATIC FEVER       |
| <input type="checkbox"/> CANCER,<br>WHERE? _____            | <input type="checkbox"/> HEART RHYTHM DISORDER   | <input type="checkbox"/> STROKE                |
| <input type="checkbox"/> CHEMOTHERAPY,<br>WHEN? _____       | <input type="checkbox"/> HEART MURMUR            | <input type="checkbox"/> TOBACCO HABIT         |
| <input type="checkbox"/> CONGESTIVE HEART FAILURE           | <input type="checkbox"/> HEART VALVE REPLACEMENT | <input type="checkbox"/> TUBERCULOSIS          |
| <input type="checkbox"/> DIABETES                           | <input type="checkbox"/> HEART PACEMAKER         | <input type="checkbox"/> THYROID PROBLEMS      |
|   | <input type="checkbox"/> HIGH BLOOD PRESSURE     | <input type="checkbox"/> VENERAL DISEASE       |
|   | <input type="checkbox"/> LOW BLOOD PRESSURE      | <input type="checkbox"/> OTHER:                |
|   | <input type="checkbox"/> MIGRAINES               | PLEASE SPECIFY _____                           |

Do you take or have taken any Bisphosphonates? Please check all that apply: How Often? \_\_\_\_\_  
 Bonfos Pill  Didronel Pill  Actonel Pill  Fosamax Pill  Boniva Pill Last treatment? \_\_\_\_\_  
 Bonfos IV  Reclast IV  Aredia IV  Zometa IV  Boniva IV  Skelid Pill

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

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

Please turn page →

**INSURANCE INFORMATION**

**PRIMARY DENTAL**

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ Group # \_\_\_\_\_ Employee ID# \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**SECONDARY DENTAL**

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ Group # \_\_\_\_\_ Employee ID# \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**DENTAL INFORMATION**

General Dentist Name: \_\_\_\_\_ Date of last dental cleaning: \_\_\_\_\_

Do you wear Partials or Dentures?  YES  NO If so, How Long? \_\_\_\_\_

Please Check All That Apply:

- Dental pain or problems now. Explain \_\_\_\_\_
- Complaints following dental treatment. Explain \_\_\_\_\_
- Fear of Dentist.
- Grind or Frequently Clench Your Teeth
- Have pain opening/closing your mouth
- Have unpleasant taste in mouth
- Have gums that bleed when brushing or flossing
- Teeth are sensitive to hot, cold or sweets
- Had problems with dental anesthesia (Novocain)
- Noticed shifting of your teeth
- Worn Braces? When? \_\_\_\_\_
- Had full mouth series of x-rays? When? \_\_\_\_\_
- Had periodontal surgery? When? \_\_\_\_\_
- Been told you have periodontal disease

## FINANCIAL POLICY

As a condition of your treatment by this office, financial arrangements must be made in advance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services.

This office will help prepare the patient's insurance forms. However, this periodontal office cannot render service on the assumption that our charges will be paid by an insurance company. Medicare Insurance will only be filed for Sleep Apnea treatment. **MEDICAID INSURANCE WILL NOT FILED BY OUR OFFICE.** Repeated insurance filings will be subject to a small administrative charge of \$10.00. A service charge of 1½ % per month (18% annual) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. We accept Cash, Checks, Visa, MasterCard, American Express and Care Credit.

## BROKEN APPOINTMENTS:

Please call our office at least 24 hours in advance to cancel or reschedule appointments. Patients that do not call and fail to show up for scheduled appointments will be charged a \$25.00 "No Show Charge".

## RELEASE OF INFORMATION

By signing this paper, you agree that we can release your information concerning the treatment necessary with your General Dentist or any other Doctor involved with your care. Please fill out the back of this page for authorization to release your information to a family member.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible  
Party Signature: \_\_\_\_\_ Relationship  
to Patient: \_\_\_\_\_

# Authorization for Release of Information

|  |                     |
|--|---------------------|
| Name of Patient _____  | Date of Birth _____ |
| <b>Walter J. Kucaba, D.D.S., M.S., P.A.</b>  |                     |
| <p>_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.</p> |                     |

| <b>Entity to Receive Information.</b><br>Check each person/entity that you approve to receive information. | <b>Description of information to be released.</b><br>Check each that can be given to person/entity on the left in the same section. |
|--|---|
| <input type="checkbox"/> Voice Mail  | <input type="checkbox"/> Results of lab tests/x-rays<br><input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Spouse  | <input type="checkbox"/> Financial<br><input type="checkbox"/> Medical as follows: _____  |
| <input type="checkbox"/> Parent (provide name) _____   | <input type="checkbox"/> Financial<br><input type="checkbox"/> Medical as follows: _____  |
| <input type="checkbox"/> Other (provide name) _____  | <input type="checkbox"/> Financial<br><input type="checkbox"/> Medical as follows _____   |

|  |
|--|
| <p><b>Patient Information</b></p> <p>I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.</p> <p>I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.</p> <p><i>I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. <u>This authorization shall be in effect until revoked by the patient.</u></i></p> |
|--|

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

**Complaints**

Complaints about your privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

This notice is effective as of \_\_\_\_/\_\_\_\_/\_\_\_\_

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date

The Notice of Privacy Practices Brochure is located in the office.