MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
○ aspirin, ibuprofen, acetaminophen, codeine _____		
○ penicillin _____		
○ erythromycin _____		
○ tetracycline _____		
○ sulfa _____		
○ local anesthetic _____		
○ fluoride _____		
○ chlorhexidine (CHX) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion, nasal breathing) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) __	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia, Crohn's, or any inflammatory bowel disease _____	☐	☐

* When checking yes, write which condition applies to you	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease)_	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. Hepatitis (type____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. difficulties with stress management _____	☐	☐
44. psychiatric treatment, antidepressants, mood stabilizers _____	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)** 

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: *When checking yes, write which applies to you

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐

GUM AND BONE	YES	NO
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth or swollen and puffy gums?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or felt them move when chewing?	☐	☐
13. Have you experienced a burning or painful sensation or metallic taste in your mouth?	☐	☐

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Kuljic DDS & Team
Center for Integrative Dentistry

Name:_____Date:_____

To help us understand and take the very best care of you today and in the future, please take a moment to answer these few but very important questions:

If you could change your smile, you would:

- ☐ Make them brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover
- ☐ Chew more easily
- ☐ Relieve pain

On a scale of 1-10, with 10 the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10
☐☐☐☐☐☐☐☐☐☐

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10
☐☐☐☐☐☐☐☐☐☐

Why did you leave your previous dentist?

_____

_____

What is the most important thing to you about your future smile and dental health?

_____

_____

What is the most important thing to you about your dental visit today?

_____

_____

Thank you for taking the time to help us help you!

LAMBERG QUESTIONNAIRE

Version 16

Associating Snoring and Sleep Apnea with Health

Kuljic DDS & Team
Center for Integrative Dentistry

1: TRADITIONAL SCREENING QUESTIONS

How well do you sleep 1-10 _____
How rested are you in the morning (when you awaken) 1-10 _____
☐ Aware that you snore?
☐ Snoring loud enough to disturb others?
☐ Been told your breathing stops while asleep?
☐ Woken up from sleep feeling like you are choking?
☐ Woken up from sleep feeling your heart race?
☐ Had a sleep study?
☐ Worn/tried a CPAP (was the pressure > 10.5cm? Y/N)
☐ BMI greater than 27?
☐ Neck size greater .17 men or 15.5 women?

2: CARDIOLOGY & VASCULAR MEDICINE

☐ High Blood Pressure or take medication for hypertension?
☐ Have you been diagnosed with (check what applies):
COPD ☐ Stroke ☐ Congestive Heart Failure ☐ Atrial Fibrillation ☐
☐ Have a pacemaker
☐ Elevated cholesterol levels?

3: PULMONOLOGY

☐ Experienced difficulty breathing during the day?
☐ Shortness of breath, even with mild exertion?
☐ Diagnosed with Asthma. Is it worse at night? Y ☐ N ☐
☐ Chronic cough, either dry or productive

4: GASTROENTEROLOGY

☐ Have heartburn or acid reflux during the day or night.
☐ Taking heartburn medications, prescription or over-the-counter (circle one)

5: NEUROLOGY

☐ Numbness ☐ tingling ☐ coldness in your feet ☐ hands ☐ head ☐
☐ Muscle weakness ☐ dizziness ☐ difficulty with coordination ☐ .

6: ENDOCRINOLOGY

☐ Diagnosed with diabetes ☐ hypothyroidism ☐ (check all that apply)
☐ Unexpectedly gained ☐ or lost ☐ weight lately?
☐ Gone through menopause? On hormone replacement therapy ☐
☐ Experience repetitive limb movement ☐ jerks in sleep ☐ urges to move legs ☐ night sweats ☐ (check all that apply)

7. OTOLARYNGOLOGY

☐ Have difficulty breathing throguh your nose?
☐ Experience dry mouth upon awakening?
☐ Have allergies that affect your ability to breathe through your nose?

8: UROLOGY

☐ Involuntarily leak urine?
☐ Night time bathroom trips
☐ Diagnosed with Benign Prostatic Hyperplasia (BPH)

9: DENTISTRY

☐ Grind your teeth while sleeping?
☐ Have you had Jaw muscle or jaw joint pain?
☐ Ringing in your ears, vertigo or dizziness?

10: PSYCHOLOGY & PSYCHIATRY

☐ Irritable when you wake up in the morning?
☐ Experience insomnia? (check all that apply) Either falling asleep ☐ or maintaining sleep? ☐
☐ Experience depression ☐ PTSD ☐ memory or concentration problems ☐ (check all that apply)
☐ Take medication for the above listed conditions?

11: RHEUMATOLOGY

☐ Been diagoned with Gout?
☐ Diagnosed with Rheumatoid Arthritis?

12: CHRONIC PAIN

☐ Often wake up with headaches or have chronic headaches.
☐ Experience chronic pain anywhere in your body?
☐ Neck / Shoulder discomfort or pain?
☐ Lower back issues?
☐ Ear issues? (check) Pressure ☐ pain ☐ vertigo ☐
☐ Do you take medications for pain daily?

1 LOW 2-3 MODERATE 4+ HIGH

Risk level of having a sleep - related breathing disorder: Date: _____ Score: _____

Name: _____ DOB: _____

Kuljic DDS & Team
Center for Integrative Dentistry

HIPAA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____City: _____ State: _____ Zip: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

SIGNATURE

I,(print name) _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Kuljic DDS & Team
Center for Integrative Dentistry

New Patient Information Form

Last Name: _____ Title: _____ First Name:_____

Preferred Name: _____

Home Address: _____

City/State/Zip Code: _____

Home Phone: _____ Cell Phone: _____

My preferred form of contact for confirmations/communication is:_____

I want to receive texts: Y / N (confirmations, scheduling & financing)

I want to receive emails: _____(confirmations and scheduling only)

I identify my gender as: M / F/ Other: _____ (fill the blank)

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

"I am aware in order to hold my appointments **I must respond to the reminders and confirm** them either by typing the letter "c" in a text message, clicking a link in an email or responding to a voicemail left at the number above":_____(initials)

SS#:_____DOB:_____

Referring Dr: _____Referring Patient: _____

Cancellation/Rescheduling Policy

As a courtesy our office employs the practice of contacting you prior to your visit to remind you of your scheduled appointments. This system has proven itself extremely effective and reliable, but please be advised that **you are ultimately responsible for keeping the appointments that you make**. If you find that you need to reschedule an appointment, please contact us within 48 hours prior to the appointment time and we will be happy to help you find a spot that works better with your schedule. However, if we do not hear from you within this acceptable time frame (either to confirm your appointment or to reschedule), then your absence is considered a "no show" or a delinquent cancellation and you will be charged a fee of $75.

In no way is it our intention to charge our patients additional money, but please understand the necessity of this policy. It is very costly to us if you miss your appointment and do not give us adequate time to schedule another patient in your reserved spot. Because your dental care is our top priority and **because we value you as a patient, your appointment time has been *solely* reserved for you**. When you do not show up, that time is completely lost, and in turn, directly affects the fees for our services.

We understand that unforeseen events occur which may prevent you from keeping your appointment which is why we have a "two strikes" cancellation policy. We are happy to forgive up to two missed appointments/late cancellations before the $75 fee applies. Beyond these two, regardless of the reason, the fee must apply. This policy enables us to maintain a high level of service for all our patients without raising our standard fees.

"I have read the above statements and verify that I am aware of the policy and the $75 fee."

Signature: _____ Date: _____

Consent for Voicemail/Answering Machine/Text Messages:

I (print)_____ give the office of Kuljic DDS & Team

authorization to leave a detailed message at (phone number)_____, and/or

(email address) _____ regarding details to an upcoming or previous

appointment I had or will have in your office, detailed information regarding a balance I have

due, or a credit that I may have to my account until further notice.

Signature: _____ Date: _____

Consent for Treatment/Finances/Appointments

I (print) _____ give the office of Kuljic DDS & Team

authorization to discuss my treatment plan, finances or any appointment I have scheduled

in your office with the members of my immediate family (names below) until further notice.

Family Member:_____

Family Member: _____

Family Member: _____

Signature:_____ Date: _____

Consent for Transfer of Funds Within My Family Account

I (print) _____ give the office of Kuljic DDS & Team

authorization to transfer funds within my family's transactions in our office, giving **credit transfers to

balances that may be due at any time, without asking for authorization for each transfer,

until further notice.

Signature: _____ Date: _____

**For example, Mom has a credit of -$14 in our office and Daughter has a balance of $9 in our office. Kuljic DDS & Team has authorization to transfer $9 from Mom's credit to Daughter's balance and there is no need to contact you for authorization for this sharing of funds. This is solely for transactions within the accounting in our office and does not require us to access your credit card/banking accounts.

Kuljic DDS & Team
Center for Integrative Dentistry

Kuljic, DDS & Team **AND YOUR INSURANCE PLAN - HOW THEY WORK TOGETHER**

The staff at ***Kuljic, DDS & Team*** is pleased that you have insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the following information regarding our insurance claims processing policies so that we can work together to best utilize your benefits.

DO YOU ACCEPT MY INSURANCE?/HOW MUCH WILL THEY PAY?

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 services*) and are in network with BCBS of MA – Indemnity. This means that we accept literally hundreds of insurance plans and companies. Although we can maintain computerized history of payment by a given company, they do change, and 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 a more exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you a more "exact" out of pocket figure you may require (based off your benefits at the time they process the authorization).

I THOUGHT I PAID MY PORTION BUT I GOT A BILL, WHY?

We base the patient portion of your bill on our most current data although there are many factors that can affect this estimate. There may be a deductible (*individual or family*) or you may have received treatment in another office prior to joining ***Kuljic, DDS & Team***, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (*and cannot in most cases*) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so we may adjust accordingly. Also, information given by insurance representatives over the phone is not a guarantee of payment or guaranteed to be accurate. Since it is your insurance plan it is also your responsibility to be familiar with all aspects of your individual plan.

INSURANCE DIDN'T PAY, NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, ***Kuljic, DDS & Team*** reserves the right to request payment in full from you for services performed and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance policy you carry 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.

FINANCIAL OPTIONS

Kuljic, DDS & Team does request payment in full for your portion at the time of service. Beside ATM Debit Cards (which are run like a credit card-no pin needed), we also accept MasterCard, VISA, American Express and Discover. If you are in need of an extended finance option, we also work with Care Credit, who offers low monthly payments with possible low fixed interest rates for those who are eligible. These plans and their benefits are designed to help meet your treatment plan needs. Just ask one of the patient service staff for an application.

We welcome you to our dental family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Kuljic, DDS & Team.

_____ _____

Signature Date