PATIENT REGISTRATION

Dental Office of Kenneth E. Mikolas DDS, LLC
227 Market Street, Leechburg, PA 15656
Phone 724-845-8380 • FAX 724-842-3371

PATIENT INFORMATION

Name: _____ Preferred: _____ Today's Date: _____

Address: _____ Gender: ☐ M ☐ F

_____ Marital Status: ☐ Married ☐ Single ☐ Child

_____ Birthdate: _____ Age: _____

_____ Social Security No.: _____

Telephone #'s: *(Home)* _____ *(Work)* _____ *(Cell)* _____ *(Other)* _____

Why did you pick our office?

☐ Friend's Referral ☐ Insurance Participation ☐ Advertisement ☐ Yellow Pages

Friend's name: _____

If you were referred by a friend, what did they say about us? _____

PATIENT EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Employer Address: _____

SPOUSAL INFORMATION

Name: _____ Birthdate: _____

Employer: _____ Occupation: _____

Employer Address: _____

INSURANCE INFORMATION

Do you have insurance coverage? ☐ Yes ☐ No

Primary Insurance Company - Name of Insurance Carrier: _____

Subscriber Name: _____ Group #: _____

ID #: _____

Secondary Insurance Company - Name of Insurance Carrier: _____

Subscriber Name: _____ Group #: _____

ID #: _____

Insurance Form Release

I hereby authorize Dr. Kenneth E. Mikolas and his staff to submit insurance forms on my behalf. I authorize release of any necessary information in order to process my insurance claim. I authorize payment of any and all benefits normally due me to be paid directly to Dr. Kenneth E. Mikolas. I understand that I am ultimately responsible for any deductible and/or co-insurance not covered by my dental plan. By signing below, I authorize the use of this signature as if I personally signed my insurance claim form.

Patient Signature: _____

FINANCIAL RESPONSIBILITY INFORMATION

Who is responsible for this account? _____ Relationship to patient? _____

Social Security No.: _____

(over please)

Patient Medical History

Patient: _____ **Date:** _____

Physician's name: Phone:

Address: Last examination:

1) Are you currently under your physician's care? ☐ Yes ☐ No *If yes, for what:*

2) Do you have any drug allergies or have you ever reacted adversely to any medication? ☐ Yes ☐ No
If yes, to what:

3) Have you ever reacted adversely to medical or dental treatment? ☐ Yes ☐ No *If yes, for what:*

4) Are you taking any medications at this time? ☐ Yes ☐ No *If yes, please list:*

5) Have you ever had any of the following? *(Please check all that apply.):*

Allergies:
- ☐ Drug
- ☐ General
- ☐ Latex

☐ **Anemia**
☐ **Arthritis**
☐ **Artificial joint(s)**
☐ **Asthma**
☐ **Back problems**
☐ **Blood disease**

Blood pressure
- ☐ High
- ☐ Low

☐ **Bone disease**
☐ **Cancer *(see box)***
☐ **Chemical dependency**
☐ **Coumadin (or other thinner)**
☐ **Chronic diarrhea**
☐ **Circulatory problems**
☐ **Diabetes**
☐ **Epilepsy**

Heart conditions:
- ☐ Artificial valve
- ☐ Attack
- ☐ Bypass

Heart conditions *(cont'd.)*:
- ☐ Disease
- ☐ Mitral valve prolapse
- ☐ Murmur
- ☐ Pacemaker
- ☐ Stent(s)

☐ **Hemophilia**
☐ **Hepatitis, jaundice, liver disease**
☐ **HIV, AIDS, other immunosuppressive diseases**
☐ **Multiple sclerosis**
☐ **Nervous disorder**
☐ **Osteoporosis (see box)**
☐ **Psychiatric care**
☐ **Recent weight loss**
☐ **Respiratory disease**
☐ **Rheumatic fever**
☐ **Sinus problems**
☐ **Swollen neck glands**
☐ **Stroke**
☐ **Tuberculosis**
☐ **Ulcers**
☐ **Venereal disease**

BISPHOSPHONATE DRUG ALERT

If you have ever been treated, or are currently being treated, for:
Cancer; osteoporosis; any disease or tumor of the bone(s); multiple mylemoma; hypercalcemia of malignancy – we must know before treatment in our office if any of these **bisphosphonate drugs** have ever been administered to you either orally or through an IV. ***(Circle all that apply)***

Drug	Brand Name	Route
Alendronate	FOSAMAX	Oral
Alendronate Cholecalciferol	FOSAMAX PLUS D	Oral
Clodronate	BONEFOS; OSTAC	IV/Oral
Etidronate (Calcium Carbonate)	DIDROCAL	Oral
Etidronate Disodium (EHDP)	DIDRONEL; GEN-ETRIDRONATE	IV/Oral
Ibandronate	BONIVA; BONDRONAT	Oral
Pamidronate	AREDIA	IV
Risedronate	ACTONEL	Oral
Tiludronate	SKELID	Oral
Zoledronic Acid	ZOMETA; ACLASTA	IV

6) ***WOMEN:*** Do you suspect you are pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

7) Height:_____ Weight:_____

8) Do you wear contact lenses? ☐ Yes ☐ No

9) What is the purpose of your visit today?

10) Is there anything else we should know about your medical history? ☐ Yes ☐ No
If so, what?:

11) In case of emergency, who should be notified? Phone #:

The above information is accurate and correct to the best of my knowledge and will be held in confidence for my treatment. I will not hold Dr. Kenneth E. Mikolas or any member of his staff responsible for any errors or ommisions that I may have made in the completion of this form.

Patient's or guardian's signature:_____ Today's date:_____ ***(over please)***

KENNETH E. MIKOLAS DDS, LLC

227 Market Street • Leechburg, PA 15656 • (724)845-8380

OFFICE FINANCIAL POLICY

Patient name: _____ Date: _____

All fees become due in full at the time of service.

Patients with Insurance:

❖ ***Please read and understand your insurance policy.*** ❖

Your policy is an agreement between you and your insurance company. It is in your best interest to know and understand your plan's general policies, deductibles, limitations and exclusions. Unlike medical insurance, dental insurers impose yearly limits and percentages on covered services.

Our participation agreement with various insurance companies **does not mean that you will not incur any out of pocket expense.** The patient (parent or guardian if the patient is a minor) is ultimately responsible. **Your individual or group policy dictates compensation from the insurance company and you.**

We will be happy to submit any insurance claims on your behalf. Upon receiving any insurance payment, you will be sent a statement for any balance remaining.

I have read & understand the above: _____ Date_____

_____

Person responsible for this account (please print)

Account Billing – All accounts:

- Any statement received is **due in full within 30 days of the statement date.**
- All unpaid accounts after 30 days will be assessed a 1.5% per month interest charge.
- Any inactive account over 90 days will be considered delinquent and automatically transferred to our collection agency or district magistrate. A collection fee of at least $15.00 will be added to the total balance due, and any and all costs will be subject to recovery.

I have read & understand the above: _____ Date_____

_____

Person responsible for this account (please print)

❖ ❖

I have read the above policy, understand its contents and agree to the terms herein. Any questions I had were answered before I endorsed this form.

_____ _____

Person responsible for this account (please print) Signature of responsible party