DENTISTRY FOR THE QUALITY CONSCIOUS
BOGDAN MADUROWICZ, D.D.S.

PATIENT REGISTRATION

PLEASE PRINT

Date _____

Patient Name _____ Date of Birth _____
Last Name First Name Initial

Address _____ City _____ State _____ ZIP _____
Apt. #

❒ Home Phone Number ( ) _____ ❒ Cell ( ) _____ Fax ( ) _____

Please check which phone number would you like our office to use when contacting you with dental information or appointment reminder calls.

Do not call before _____ AM or after _____ PM E-Mail *(Appointment Reminders)* _____

Dr. License # _____ Sex ❒ M ❒ F Age _____ ❒ Single ❒ Married ❒ Separated ❒ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Spouse/Parent Name _____ Phone ( ) _____

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

Whom may we thank for referring you? _____

We would like to place a gift certificate on the referring patient account to thank them for sharing us with a friend or family members.

Social Security Number _____ *Required for insurance billing and credit applicants only. All information acquired is kept within this office. All correspondence with personal information is shredded. Insurance claims are sent via secure lines. X-rays are sent via e-mail or postal with consent.*

PRIMARY DENTAL INSURANCE

Employee _____ Date of Birth _____

Employer _____ ❒ Single Coverage ❒ Family Coverage

Dental Insurance Carrier _____

Claims Address _____ City _____ State _____ ZIP _____
Unit/Suite #

800 Number ( ) _____ Group ID# _____ SS# or ID# _____

SECONDARY DENTAL INSURANCE

Employee _____ Date of Birth _____

Employer _____ ❒ Single Coverage ❒ Family Coverage

Dental Insurance Carrier _____

Claims Address _____ City _____ State _____ ZIP _____
Unit/Suite #

800 Number ( ) _____ Group ID# _____ SS# or ID# _____

718 N. Coast Highway 101 Encinitas, CA 92024
P 760.753.7185 | http://dr.madurowicz.com

DENTAL HISTORY

THE THOROUGHNESS OF THIS DENTAL HISTORY QUESTIONNAIRE IS DESIGNED FOR YOUR SAFETY.
COMPLETE ANSWERS WILL ASSIST US IN TREATING YOU WITH CONSIDERATION FOR YOUR INDIVIDUAL NEEDS.

Reason for today's visit _____

Former dentist _____

Phone ( ) _____ Date of last dental care _____ Date of last dental x-rays _____

CHECK IF YOU HAVE/HAD ANY OF THE FOLLOWING

❒ Bad breath
❒ Dry mouth
❒ Bleeding gums
❒ Loose teeth or broken filings
❒ Clicking or popping jaw
❒ Periodontal treatment
❒ Food collecting between teeth
❒ Sores or growths in your mouth
❒ Are your teeth sensitive to Hot or Cold? (Circle one)
❒ Do any of your teeth hurt biting down?
❒ Are your teeth sensitive eating sweets?

HOW OFTEN DO YOU BRUSH? _____ HOW OFTEN DO YOU FLOSS? _____

1. ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? ❒ Yes ❒ No

2. IF UNHAPPY, WHAT CHANGE WOULD YOU MAKE? _____

3. HAVE YOU EVER BLEACHED YOUR TEETH? ❒ Yes ❒ No

4. ARE YOU INTERESTED IN LEARNING ABOUT HOW COSMETIC DENTISTRY CAN BENEFIT YOU? ❒ Yes ❒ No

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges. Payment for procedures are due at the time of service unless other arrangements have been made prior to completing procedures. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. Insurance benefits will be sent directly to the subscriber. I will be responsible for understanding my insurance benefits and frequency limitations. I authorize the use of this signature on all my insurance submissions manual or electronic. I authorize the doctor to share information with dental specialists, and staff members that are involved with my dental care. All information is confidential.

Signature _____ Date _____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform the necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature _____ Date _____

MEDICAL HISTORY

THE THOROUGHNESS OF THIS MEDICAL HISTORY QUESTIONNAIRE IS DESIGNED FOR YOUR SAFETY. COMPLETE ANSWERS WILL ASSIST US IN TREATING YOU WITH CONSIDERATION FOR YOUR INDIVIDUAL NEEDS.

Name of Primary Care Physician _____ Phone ( ) _____

Additional Physician _____ Specialty _____ Phone ( ) _____

1. DO YOU HAVE A CURRENT MEDICAL PROBLEM? ❒ Yes ❒ No

If yes, please describe _____

2. ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ❒ Yes ❒ No

If yes, please describe _____

3. HAVE YOU EVER TAKEN A BIOSPHOSPHOMATE MEDICATION? (ie. Fosomax, Actonel, Zomeda, Aredia) ❒ Yes ❒ No

4. IF FEMALE, ARE YOU PREGNANT? IF SO, HOW FAR ALONG? _____ months

Please describe the use of any drugs or discuss in complete confidentiality with the doctor. The use of recreational drugs, such as cocaine, stimulants and others may have a fatal interaction with local anesthetics or other common dental medications.

PLEASE INDICATE WHICH ONES

❒ Heart Medication	❒ Blood Pressure Medication	❒ Nitroglycerine	❒ Antibiotics
❒ Sedatives	❒ Tranquilizers	❒ Herbal Supplements	❒ Pain Medications
❒ Cortisone (steroids)	❒ Blood Thinners	❒ Birth Control Pills	❒ Vitamins
❒ Anti-anxiety	❒ Anti-depressant	❒ Other Medication	

Name of Medication _____ Dosage _____ Purpose _____

5. ARE YOU ALLERGIC TO ANY MEDICINES/PRODUCTS OR HAVE YOU HAD ANY UNUSUAL REACTION TO ANY MEDICATIONS AND/OR PRODUCTS? HAVE YOU BEEN TOLD NOT TO TAKE PARTICULAR MEDICATIONS?

If yes, please describe _____

❒ Yes ❒ No Penicillin	❒ Yes ❒ No Tylenol	❒ Yes ❒ No Novocaine
❒ Yes ❒ No Erythromycin	❒ Yes ❒ No Ibuprofen	❒ Yes ❒ No Xylocaine
❒ Yes ❒ No Other Antibiotics	❒ Yes ❒ No Epinephrine	❒ Yes ❒ No Lidocaine
❒ Yes ❒ No Sulfa Drugs	❒ Yes ❒ No Carbonate	❒ Yes ❒ No Fluoride
❒ Yes ❒ No Latex	❒ Yes ❒ No Silica	

Allergic Reaction _____ How long ago did you have the reaction? _____

See reverse (Medical History continued)

MEDICAL HISTORY CONTINUED

6. CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD OR HAVE AT THE PRESENT

❒ Mitral Valve Prolapse	❒ Liver Disease	❒ Arthritis	FOR DOCTOR'S USE _____
❒ Artificial Joint (Prosthesis)	❒ Hemophilia	❒ Diabetes	_____
❒ Heart Failure/Attack	❒ Thyroid Disease	❒ Blood Transfusion	_____
❒ Prosthetic Heart Valve	❒ Kidney Disease	❒ Cold Sores	_____
❒ Angina	❒ Head/Neck Injury	❒ Cancer/Chemotherapy	_____
❒ High Blood Pressure	❒ Back Injury	❒ Osteoporosis	_____
❒ HIV positive/AIDS	❒ Hepatitis (A, B or C)	❒ Asthma	_____
			_____

7. PATIENT HABITS

❒ Yes	❒ No	Pipe/Cigar/Cigarette Smoking	❒ Yes	❒ No	Do you Snore?	❒ Yes	❒ No	Tongue Thrusting
❒ Yes	❒ No	Smokeless Tobacco Use	❒ Yes	❒ No	Sleep Apnea	❒ Yes	❒ No	Mouth Breathing
❒ Yes	❒ No	Nail Biting	❒ Yes	❒ No	Treated for TMJ	❒ Yes	❒ No	Substance Abuse
❒ Yes	❒ No	Gum Chewing	❒ Yes	❒ No	Anorexia /Bulimia	❒ Yes	❒ No	Headaches
❒ Yes	❒ No	Teeth Grinding/Clenching	❒ Yes	❒ No	Cheek Biting			

❒ Yes ❒ No Do you have difficulty opening your mouth wide? ❒ Yes ❒ No Have you had Orthodontic Treatment?

❒ Yes ❒ No Do you wear a retainer? ❒ Yes ❒ No Do your joints click when you chew?

❒ Yes ❒ No Have you had Nitrous Sedation with dentistry?

8. HAVE YOU HAD A BAD DENTAL EXPERIENCE IN THE PAST? ❒ Yes ❒ No

If yes, please describe _____

9. ARE YOU CURRENTLY BEING TREATED FOR A MEDICAL/DENTAL CONDITION? ❒ Yes ❒ No

If yes, please describe _____

10. IS THERE ANYTHING ELSE ABOUT YOUR MEDICAL/DENTAL HISTORY WE SHOULD BE AWARE OF? ❒ Yes ❒ No

If yes, please describe _____

I hereby grant authority to the dentist(s) in charge of the patient whose name appears on this health history form to administer any treatment and to administer such x-rays, anesthetics or sedative/ and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Signature _____ Date _____

Relationship (if patient is a minor or physically or mentally disabled) _____ Date _____

IF MINOR,

Guardian Signature _____ Date _____

FINANCIAL AGREEMENT

FOR THE OFFICE OF

BOGDAN R. MADUROWICZ, DDS

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement.

As a courtesy to you, we will help you process all your insurance claims. In order for our practice to file your insurance claim properly you will be asked for up-to-date insurance information. All insurance benefits will be assigned to you. If any insurance benefit checks are accidentally sent to us and your account balance is zero, we will refund you the amount within the week it is received. We will process all your insurance claims and your dental benefits will be mailed directly to you.

Payments for services rendered are due at the time treatment is provided. For your convenience, our practice accepts MasterCard, Visa, American Express, and Discover, as well as cash and personal checks. Third party, extended payment financing is available upon request and credit approval. Other payment arrangements will be considered on a "need basis" and should be discussed with the front office prior to any services. Returned checks and unpaid balances older than 60 days will be subject to a collection fee of $50.00 as well as possible interest charges of 18% per annum. 90-day past due accounts are sent to a collection agency.

Time is a very valuable asset that we continually respect and expect the same in return. Please be informed our cancellation fee for missed and rescheduled appointments without a 48 hour notice is $50.00 per hygiene hour and 15% of the procedure fee with Dr. Madurowicz. Emergencies will be understood. Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with an excellent experience in dental care.

Print Name of Patient _____ Date _____

Signature of Patient or Responsible Party _____

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