Kotary, Detar and Associates

Family and Cosmetic Dentistry
2014 Sandy Drive, State College, PA 16803
814-238-2431

Edmond M. Kotary, D.M.D. **April A. Detar, D.M.D.**

Welcome!

It is our optimal goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment. In order to keep our standard of care to a level which best serves your dental needs, we ask you to please observe the following guidelines:

Appointment and Cancellation Policies

Dental health is not a one-time affair. A plan of preventive dentistry along with a mutual understanding of joint responsibility for your dental health is the most important service we have to offer you. To remain an active patient in this office you will be included in our Preventive Dental Care Program and **expected** to have a regular periodic examination and professional cleaning at least twice a year.

There are many times that our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give our office advanced notice of their need to cancel a scheduled appointment, this time can then in turn be allocated to these patients in urgent need of treatment. In this way the office can best serve the needs of ALL patients.

Bearing these special needs in mind the office requires a minimum of two (2) **business** days notice if an appointment must be canceled. If less than 2 **business** days notice has been given to cancel an appointment or the patient does not show up for their scheduled appointment, a missed appointment fee of $75 will be assessed. Please note that this fee is not covered by dental insurance. Payment is the patients' responsibility and must be paid before additional treatment is scheduled or performed.
*Exceptions are made for illness or personal tragedy.

Payment Policy

Unless prior arrangements have been made, payment is due upon completion of treatment. Please note, your insurance carrier may not cover all services and every insurance plan has its own unique "quirks" and exceptions. **It becomes the patients' responsibility to cover procedures that are not covered by their insurance plan.**

We at Kotary, Detar & Associates look forward to taking care of your oral health needs and welcome you and your family to our team of dental professionals. If at any time you have a question or are unhappy about any treatment, fee or service, please discuss it with us promptly and openly. Our goal is for a long-term mutually satisfying relationship.

I have read the above policies of Kotary, Detar & Associates Dental Care and understand my responsibility as a patient.

____
Patient Name Printed

______________________________ ______________________
Patient Signature Date

Revision 10/16/14

PATIENT INFORMATION FORM

NAME (Last, First, Middle):_________________________________ TITLE:_____

ADDRESS:____

PREFERRED NAME:_____________ SS NO:______________ DOB: ___/___/___

HOME PHONE: (___)____-_______ MARITAL: _____________ SEX: __________

WORK PHONE: (___)____-_______ REF. PATIENT:__________________________

CELL PHONE: (___)____-________ EMAIL: _______________________________

MEDICAL ALERTS:

____

____

PRIMARY DENTAL INSURANCE COVERAGE

SUSCRIBER NAME:__________________________ RELATION TO PATIENT:_________

ADDRESS:____

SS NO:_______________ EMPLOYER:_______________________________________

DOB:____/____/_____ ADDRESS: ____

PLAN NAME:_______________ GROUP NO:____________________

INSURANCE CO: ___________________________ PHONE: (___)_____-__________

ADDRESS:____

SECONDARY DENTAL INSURANCE COVERAGE

SUSCRIBER NAME:_________________________ RELATION TO PATIENT:__________

ADDRESS:____

SS NO:_______________ EMPLOYER:_______________________________________

DOB:____/____/_____ ADDRESS:____

PLAN NAME:______________ GROUP NO:______________________

INSURANCE CO:_________________________ PHONE: (___) _____-_________

ADDRESS: ____

RESPONSIBLE PARTY

NAME AND ADDRESS:____

SIGNATURE: ____

SIGNATURE ON FILE

- ☐ I AUTHORIZE USE OF THIS FORM ON **ALL** MY INSURANCE SUBMISSIONS.
- ☐ I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.
- ☐ I UNDERSTAND THAT **I AM RESPONSIBLE** FOR MY DENTAL BILL.
- ☐ I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES.
- ☐ I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR.
- ☐ I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
- ☐ MY SIGNATURE ALSO APPLIES TO ALL DEPENDENTS LISTED ON MY INSURANCE PLAN.

SIGNATURE: ____

DATE: ____________________________

KOTARY, DETAR & ASSOCIATES

Patient Record of Disclosures

I would like to be contacted in the following manner (please check all that apply):

Home Telephone # (   ) ___________________________

- □ It is okay to leave a message with detailed information.
- □ Leave a message with *only* a callback number.

Cell Phone # (   ) ___________________________

- □ It is okay to leave a message with detailed information.
- □ Leave a message with *only* a callback number.

Work Telephone # (   ) _____________________________

- □ It is okay to leave a message with detailed information.
- □ Leave a message with *only* a callback number.

Written Communication

- □ It is okay to mail information to my home address.
- □ It is okay to mail information to my work/office address.
- □ It is okay to fax information to this number ____________________.
- □ It is okay to e-mail information to this e-mail address _____________@____________

□ Other ____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual also has the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Our office utilizes secure online bill pay through email. To opt out, please check here: □

Patient/Guardian Signature: ____________________________________ Date: ______________

PATIENT NAME (IF MINOR) _____________________________________

Patient Name: ______________________________ Date: ________________

MEDICATION LIST

When filling this out, include the dosage of the medication.
If more space is needed, attach a separate page

Medication	Dosage

Patient Medical History

Name: ______________________________ Date: ______________________

For the following questions, please check Yes or No. Your answers are for our records only and will be confidential. Please note that during your initial visit you may be asked some questions about your responses. Our team may ask additional questions concerning your health.

Yes	No	Condition
		Abnormal Bleeding
		Alcohol Abuse
		Allergies
		Anemia
		Angina Pectoris
		Arthritis
		Artificial Bones
		Artificial Heart Valve
		Asthma
		Blood Transfusion
		Cancer
		Chemotherapy - Cancer
		Colitis
		Congenital Heart Defect
		Diabetes
		Difficulty Breathing
		Drug Abuse
		Emphysema
		Epilepsy
		Fainting Spells
		Fever Blisters
		Frequent Headaches
		Glaucoma

Yes	No	Condition
		Hay Fever
		Heart Attack
		Heart Surgery
		Hemophilia
		Hepatitis A
		Hepatitis B
		High Blood Pressure
		HIV+ AIDS
		Kidney Problems
		Liver Disease
		Low Blood Pressure
		Mitral Valve Prolapse
		Pace Maker
		Pneumocystitis
		Psychiatric Problems
		Radiation Therapy
		Rheumatic Fever
		Seizures
		Sickle Cell Disease
		Sinus Problems
		Stroke
		Thyroid Problems

Yes	No	Conditions
		Tuberculosis
		Ulcers
		Venereal Disease
		Yellow Jaundice
		PREMED-Joint Replacement
		PREMED-Mitro Valve
		Abnormal Heart
		Heart Stent
		Heart Valve (Artificial)
		Heart Transplant
		Hepatitis C
		Inflammatory Disease
		Joint Replacement
		Osteoporosis
		Bacterial Endocarditis
		Previous Biopsies
		Recurrent Illnesses
		Slow Healing Mouth Sores
		Sore/Enlarged Lymph Nodes
		Unintentional Weight Loss/Gain

Yes	No	
		Do you smoke or use tobacco?
		Do you wear contact lenses?
		Have you been advised to PREMED before dental treatment?
		Have you been hospitalized in the last 5 years?
		Have you ever been treated with Bisphosphonate drugs? (Fosamax, Aredia, Zometa, Actonel or Boniva)

If yes, when did treatment begin? ______________________

If yes, when did treatment end? ______________________

Date of last health care exam? ______________________

Yes	No	Allergies
		Aspirin
		Codeine
		Dental Anesthetics
		Erythromycin
		Jewelry
		Latex
		Metals
		Penicillin
		Tetracycline
		Antibiotics
		Ibuprofen
		Tylenol
		Other: ________________________

Please list names and phone numbers of all physicians currently providing you care:

1 ____ ____________________________

2 ____ ____________________________

3 ____ ____________________________

If female, please answer the following:

Yes	No	
		Are you taking birth control pills?
		Are you pregnant?
		If pregnant, # of weeks? _______
		Are you nursing?

Height: _________________ Weight: ________________

FOR OFFICE USE ONLY:

BP: ______________________________

Heart Rate: _____________________

KOTARY, DETAR & ASSOCIATES

Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

Please Print Name **Date of Birth**

Signature

Date

Is there anyone in your household with whom we may NOT discuss your care or account? If so, please indicate below.

If you have a designated personal representative, please indicate that person's name, date of birth, and contact information below.

Name **Date of Birth**

Address

Phone Number (s) **Email**