Patient Registration Form

Paula I Yapo. DDS
809 SUMMIT AVENUE
GREENSBORO, NC 27405
(336) 272-4193

American Dental Association
www.ada.org

Email: Today's Date:

Preferred Name: ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Referred by:

Name: Last First Middle Home Phone: include area code ( ) Cell Phone: include area code ( )

Address: Mailing address City: State: Zip:

SS#: Date of Birth: Sex: M F

Employer: Business Phone: include area code ( )

Emergency Contact: Relationship: Home Phone: include area code ( ) Cell Phone: include area code ( )

College Student Status: ☐ Full Time ☐ Part Time Please provide school info: School Name:

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Address:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Address 2:

Pref. Pharmacy: Phone: ( ) City, State, Zip:

Dental Insurance Information

Primary Insurance Information

Name of Insured: Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Secondary Insurance Information

Name of Insured: Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatments?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

over

Patient Name _____ DOB _____

Medical Information

Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Are you now under the care of a physician?	❑	❑	❑
Physician Name: _____			
Phone: *include area code* ( ) _____			
Address/City/State/Zip: _____			
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
If yes, what condition was treated? _____			
Date of last physical exam: _____			
Do you wear contact lenses?	❑	❑	❑
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)?	❑	❑	❑
Are you taking or scheduled to begin taking either of the medications alendrontate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?	❑	❑	❑
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer?	❑	❑	❑
Date Treatment Began: _____			

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	❑	❑	❑
If yes, what was the illness or problem? _____			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	❑	❑	❑
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____			
Do you use controlled substances (drugs)?	❑	❑	❑
Do you use tobacco (smoking, snuff, chew, bidis)?	❑	❑	❑
If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	❑	❑	❑
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are you:			
Pregnant?	❑	❑	❑
Number of weeks: _____			
Taking birth control pills or hormone replacement?	❑	❑	❑
Nursing?	❑	❑	❑

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? ❑ ❑ ❑

Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to, or have you had a reaction to: To all **yes** responses, specify type of reaction.	Yes	No	DK
Local anesthetics _____	❑	❑	❑
Aspirin _____	❑	❑	❑
Penicillin or other antibiotics _____	❑	❑	❑
Barbituates, sedatives, or sleeping pills _____	❑	❑	❑
Sulfa drugs _____	❑	❑	❑
Codeine or other narcotics _____	❑	❑	❑
Metals _____	❑	❑	❑
Latex (rubber) _____	❑	❑	❑
Iodine _____	❑	❑	❑
Hay fever / seasonal _____	❑	❑	❑
Animals _____	❑	❑	❑
Food _____	❑	❑	❑
Other _____	❑	❑	❑

	Yes	No	DK
Heart murmur	❑	❑	❑
Mitral valve prolapse	❑	❑	❑
Artificial heart valves	❑	❑	❑
Rheumatic fever	❑	❑	❑
Cardiovascular disease	❑	❑	❑
Angina	❑	❑	❑
Arteriosclerosis	❑	❑	❑
Congestive heart failure	❑	❑	❑
Coronary artery disease	❑	❑	❑
Damaged heart valves	❑	❑	❑
Heart attack	❑	❑	❑
Low blood pressure	❑	❑	❑
High blood pressure	❑	❑	❑
Congenital heart defects	❑	❑	❑
Pacemaker	❑	❑	❑
Rheumatic heart disease	❑	❑	❑
Abnormal bleeding	❑	❑	❑

	Yes	No	DK
Anemia	❑	❑	❑
Blood transfusion	❑	❑	❑
If yes, date: _____			
Hemophilia	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Arthritis	❑	❑	❑
Autoimmune disease	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Sinus trouble	❑	❑	❑
Tuberculosis	❑	❑	❑
Cancer/Chemotherapy/ Radiation treatment	❑	❑	❑

	Yes	No	DK
Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Diabetes Type I or II	❑	❑	❑
Eating disorder	❑	❑	❑
Malnutrition	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux/Persistent heartburn	❑	❑	❑
Ulcers	❑	❑	❑
Thyroid problems	❑	❑	❑
Stroke	❑	❑	❑
Glaucoma	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑

	Yes	No	DK
Neurological disorders	❑	❑	❑
If yes, specify: _____			
Sleep disorder	❑	❑	❑
Mental health disorders	❑	❑	❑
If yes, specify: _____			
Recurrent infections	❑	❑	❑
Type of infection: _____			
Kidney problems	❑	❑	❑
Night sweats	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck	❑	❑	❑
Severe headaches/ Migraines	❑	❑	❑
Severe of rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Excessive urination	❑	❑	❑

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ ❑ ❑

Name of physician or dentist making recommendation: _____ Phone: (_____) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ❑ ❑ ❑

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will reyl on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Paula I. Kapec, DDS
809 SUMMIT AVENUE
GREENSBORO, NC 27405
(336) 272-4193

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows **Paula I Kapec D.D.S., PLLC** to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ (mm/dd/yyyy) **Main Contact Number:** (___) _____

Mailing Address: _____

COMMUNICATING WITH YOU

Selecting the SMS checkbox acknowledges receipt of SMS correspondence from Paula I Kapec DDS PLLC. Message & data rates may apply. Reply STOP to opt out.

PHONE	DETAILED MESSAGES PERMITTED		
☐ Main Contact Number Above	☐ text (SMS)*	☐ voicemail/answering machine	☐ None
☐ Other: (___) _____ ☐ Home ☐ Cell* ☐ Work	☐ text (SMS)*	☐ voicemail/answering machine	☐ None

EMAIL*

☐ Email Address _____

☐ All information from this practice	☐ Data breach notifications
☐ Appointment information only (request/confirm/cancel)	☐ Billing/insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may communicate to the **family members, friends, or caregivers** listed below (LIST FIRST AND LAST NAME)

Spouse/Partner: _____	Other: _____
Phone: (___) _____	Phone: (___) _____
Email:* _____	Email:* _____
	Relationship: _____

Check the box next to each type of information this practice may share.

☐ All information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance

☐ Other: _____

Do not include:

☐ Mental health records ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

See Back →

Paula I. Kapec. DDS
809 SUMMIT AVENUE
GREENSBORO, NC 27405
(336) 272-4193

YOUR PHOTOS & MULTIMEDIA

☐ **Photos/Images may be used/posted** (select options below)	☐ **Photos/Images may NOT be used/posted**
☐ Photo received from you or personal representative	☐ In office
☐ Photo taken by staff (e.g., pre/post procedure)	☐ On office's website
☐ Other:_____	☐ Other: _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

_____ _____

(Patient/Personal Representative Signature) **(Date)**

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: _____

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: _____

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes:

_____

Paula I Kapec, DDS
809 SUMMIT AVENUE
GREENSBORO, NC 27405
(336) 272-4193

Patient Financial Responsibility Disclosure

At Paula I Kapec D.D.S., PLLC, we are dedicated to delivering the highest quality dental care. This document serves to delineate the financial responsibilities of patients concerning their dental care and insurance coverage.

Understanding of Fees and Insurance Responsibility

I, the undersigned, acknowledge and accept full responsibility for the payment of all fees associated with the dental services rendered by Paula I Kapec D.D.S., PLLC. I understand that dental insurance is designed to assist with the cost of treatment, but it may not cover the entirety of the expenses incurred. Consequently, I am responsible for any portion of fees not covered by my insurance provider.

I recognize that my dental insurance policy is a contractual agreement between my insurance company and myself, and that Paula I Kapec D.D.S., PLLC is not a party to this contract. I agree to bear full financial responsibility for any charges not paid by my insurance company, irrespective of the reason for non-payment.

Assignment of Benefits

I understand and acknowledge that my dental insurance company may disburse benefit payments directly to me as the plan subscriber. **I commit to presenting any physical insurance check received for services rendered by Paula I Kapec D.D.S., PLLC to the dental office within thirty (30) days from the date of services rendered.** If I do not have physical payment, I agree to contact the office to notify Paula I. Kapec DDS, PLLC of any payment delays within thirty (30) days from the date services are rendered."

Statement and Collection Policy

Monthly statements will be sent to all patients electronically, via email and/or text message, regardless of insurance claim status. Effective 5/31/23, it is my responsibility to confirm and update my email address and phone number on file.

I understand that if a balance remains on my account for more than 60 days, I may be required to render payment before additional services are performed.

In the event my account is sent to collections status, I will be responsible for any additional fees incurred. My signature below confirms that I am fully responsible for the full fee of the treatment performed, irrespective of the outcome from my insurance company's processing of the claim.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

SEE BACK ----->

Paula I. Kapec DDS
809 SUMMIT AVENUE
GREENSBORO, NC 27405
(336) 272-4193

Out-of-Network Insurance Policy Acknowledgment

Please note that our office is *only in-network with Cigna*. If your dental insurance is through a provider other than Cigna, we are considered out-of-network.

When we are out-of-network with your insurance plan, we do not have access to the allowable fee schedule, or the maximum reimbursement amounts your plan may provide. This information is not disclosed to us by your insurance company.

Therefore, all coverage estimates are based solely on the information we can obtain, which may include:

- Online benefit breakdowns through your insurance portal
- Verbal confirmations with insurance representatives
- Faxed information, when available

Please understand that any cost estimates we provide are not guarantees of payment and are based on the best available information at the time.

If we are out-of-network with your insurance, you have two options for managing payment:

1. Pay the Estimated Portion at Time of Service

You may pay the estimated portion at the time of your appointment, with the full understanding that it is only an estimate. After your insurance processes the claim, you will be responsible for any remaining balance.

2. Pay in Full and Seek Reimbursement

You may choose to pay in full at the time of service. In this case, we will submit the claim on your behalf, and your insurance company will reimburse you directly. Please note: If there are any issues with the claim or reimbursement, you will need to work directly with your insurance provider to resolve them.

Important: Your dental insurance policy is a contract between you and your insurance company.

As an out-of-network provider, we are not privy to all the terms or reimbursement policies specific to your plan. Please sign below to acknowledge that you have read, understood, and agree to our Out-of-Network Insurance Policy.

Patient Name: _____

Patient/GuardianSignature: _____

Date: _____

Paula I. Kapec, DDS
809 SUMMIT AVENUE
GREENSBORO, NC 27405
(336) 272-4193

Cancellation and Missed Appointment Policy

Our goal at *Paula I. Kapec, DDS, PLCC* is to provide our patients with quality and convenient care. Since your appointment time is reserved specifically for you, late cancellations and missed appointments may prevent others from receiving necessary services.

We understand that situations may arise that require you to reschedule an appointment. When possible, we ask that you change your appointment at least **48 hours** in advance by calling or messaging our office at (336) 272-4193.

In the event of a missed **("no-show") appointment, or cancellations without a 24 hour notice, a fee of $50/hour of scheduled service time may be applied to your account.**

These fees must be paid before another appointment can be scheduled. Multiple missed appointments may result in dismissal from the practice.

We appreciate the opportunity to care for you here at *Paula I. Kapec, DDS, PLLC*!

Print Name: _____

Signature: _____

Date: _____

By signing, you acknowledge that you have read and understand our Cancellation and Missed Appointment Policy.

Updated 10/22/2024