KULICK DENTAL GROUP

8890 Royal Palm Blvd, Coral Springs, FL 33065
Telephone: 954-341-0500 Fax: 954-775-0547

MEDICAL HISTORY FORM

Please complete both sides of this medical/dental history form so that we may provide you with the best possible dental care in a safe and efficient manner. Please answer to the best of your knowledge. All information is completely confidential.

Patient Name: _____ Date of birth: _____ Today's date: _____

Home Address:_____City: _____State: _____Zip code: _____

Email address: _____Sex: _____ Occupation:_____

Driver's License :_____Social security number: _____

Emergency contact Name:_____ Phone number: _____ Relationship: _____

Dental insurance company:_____ Policy number:_____

Person responsible for account :_____Driver's license: _____ Phone number: _____

Preferred Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____City: _____State: _____Zip code: _____

Physician Name: _____Physician Phone Number: _____

Physician Address: _____City: _____State: _____Zip code: _____

Previous Dentist Name _____ Previous Dentist Phone Number: _____

Previous Dentist Address: _____City: _____State: _____Zip code: _____

Are you currently taking any medication? ☐ Yes ☐ No For what purpose? _____

Please list the name of all current medications: _____

_____

Have you ever been diagnosed or treated for any of the following:

☐ High Blood pressure
☐ Low Blood pressure
☐ Chest Pain
☐ Cardiac Disease
☐ Heart Surgery/Artificial Valve/Heart Stent
☐ Pacemaker placement
☐ Anticoagulants or Blood thinners
☐ Joint Replacement (Hip, Knee)
☐ CVA/Stroke
☐ Diabetes ☐ Type I ☐ Type II
☐ Cancer
☐ Radiation Therapy
☐ Osteoporosis/Osteopenia
☐ Bisphosphonate Therapy
☐ Renal insufficiency/dialysis
☐ Liver Disease/Cirrhosis
☐ Hepatitis B
☐ HIV/AIDS
☐ Tuberculosis
☐ Thyroid Disease
☐ Glaucoma
☐ Arthritis
☐ Psoriasis
☐ Rheumatic fever
☐ Sinus problems
☐ Lung Disease
☐ Chronic Obstructive Pulmonary Disease
☐ Asthma
☐ Sleep Apnea
☐ Hemophilia
☐ Sickle Cell Disease
☐ Neurological Disorders
☐ Epilepsy or Seizures
☐ Psychiatric or Phycological Care
☐ GERD or Acid Reflux
☐ Latex sensitivity
☐ Allergies: _____

Have you ever been told to premedicate with antibiotics before a dental? ☐Yes ☐ No

Have you had any surgeries? ☐ Yes ☐ No For what purpose: _____

Are you currently pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

KULICK DENTAL GROUP

8890 Royal Palm Blvd, Coral Springs, FL 33065
Telephone: 954-341-0500 Fax: 954-775-0547

MEDICAL HISTORY FORM

Please complete both sides of this medical/dental history form so that we may provide you with the best possible dental care in a safe and efficient manner. Please answer to the best of your knowledge. All information is completely confidential.

What's the reason for your visit today?_____

When was your last dental visit? _____ For what purpose? _____

Are you satisfied with your dental appearance? ☐ Yes ☐ No. Please explain _____

Do you get regular dental care? ☐ Yes ☐ No When was your last dental cleaning? _____

Have you ever had any serious trouble associated with previous dental treatment? ☐ Yes ☐ No

Are you nervous or anxious during dental visits? ☐ Yes ☐ No

Do you brush your teeth? ☐ Yes ☐ No How often? _____ Do you floss? ☐ Yes ☐ No How often? _____

Do you use mouthwash? ☐ Yes ☐ No How often? _____ Do you use topical fluoride for caries prevention? ☐ Yes ☐ No

Do you Smoke ☐Yes ☐No Type of smoking: ☐Cigarettes ☐Cigars ☐Vaping ☐Pipe ☐Other _____

How often do you smoke? _____ For how long have you smoked? _____

Do you chew tobacco? ☐Yes ☐No How often? _____ For how long? _____

Are you experiencing?

Sensitivity to hot or cold	☐ Yes ☐ No
Sensitivity to sweets	☐ Yes ☐ No
Pain to biting or chewing	☐ Yes ☐ No
Mouth odors or bad taste	☐ Yes ☐ No
Suppuration	☐ Yes ☐ No
Swelling of your face	☐ Yes ☐ No
Mouth ulcers or blisters	☐ Yes ☐ No
Bleeding or painful gums	☐ Yes ☐ No
Loose teeth/change in your bite	☐ Yes ☐ No

Do you:

Clench or grind your teeth awake or sleep	☐ Yes ☐ No
Bite your lips or cheeks regularly	☐ Yes ☐ No
Hold foreign objects with your teeth	☐ Yes ☐ No
Mouth breath awake or sleep	☐ Yes ☐ No
Have tired jaws, especially in the morning	☐ Yes ☐ No
Snore	☐ Yes ☐ No
Stop breathing during your sleep	☐ Yes ☐ No
Gag easily	☐ Yes ☐ No

Have you ever had:

Orthodontic treatment or braces	☐ Yes ☐ No
Oral surgery or dental implants	☐ Yes ☐ No
Gum or periodontal treatment	☐ Yes ☐ No
TMJ treatment	☐ Yes ☐ No
Bite adjustment	☐ Yes ☐ No
Mouthguard	☐ Yes ☐ No
Retainers	☐ Yes ☐ No
Sleep appliance	☐ Yes ☐ No
Serious injury on your mouth/head	☐ Yes ☐ No

Have you experienced:

Clicking or popping of the jaw	☐ Yes ☐ No
TMJ pain	☐ Yes ☐ No
Pain on ear or side of the face	☐ Yes ☐ No
Difficulty opening/closing your mouth	☐ Yes ☐ No
Difficulty chewing	☐ Yes ☐ No
Headaches, neck aches, or shoulder aches	☐ Yes ☐ No
Lock or stuck jaw	☐ Yes ☐ No

_____
Patient or Legal Guardian Signature

_____
Date

KULICK DENTAL GROUP
8890 Royal Palm Blvd, Coral Springs, FL 33065
Telephone: 954-341-0500 Fax: 954-775-0547

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

I understand that under the Health Insurance Portability and Accountability Act (HIPPA) of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received, read, and understand your Notice od Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but if you do not agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship: ___Self ___Legal Guardian

Patient or Legal Guardian Signature:_____ Date: _____

I give permission to disclose details of my account, chart, and conditions to the following people.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

KULICK DENTAL GROUP
8890 Royal Palm Blvd, Coral Springs, FL 33065
Telephone: 954-341-0500 Fax: 954-775-0547

PHOTOGRAPHY CONSENT FORM

I give consent to my doctor and authorized members of KULICK DENTAL GROUP and IGLESIAS DENTISRY LLC to take photographs and/or videos of my face, mouth, teeth, and jaws, before and after treatment. I consent to allow these photographs to be used for the following professional purposes:

- Dental Records, case assessment and treatment plan coordination.
- Dental Research.
- Dental Education for myself and others, including but not limited to training purposes, lectures, and presentations.
- Marketing material and advertisements, including limited use on social media, websites, printed materials, and in-office demonstrations.

I further understand that if the photographs and/or videos are used, my name and other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of my photographs and/or videos.

I understand that the practice cannot condition the treatment I receive based on whether I sign this authorization.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

☐ **I don't want my full-face photograph used for any of the above purposes.** This means that only photos of my teeth, jaws, and mouth be used, without showing my full face.

☐ I wish to have a copy of this signed form to take home for my own record keeping.

Patient Name: _____

Patient or Legal Guardian Signature:_____ **Date:**_____

KULICK DENTAL GROUP
8890 Royal Palm Blvd, Coral Springs, FL 33065
Telephone: 954-341-0500 Fax: 954-775-0547

BILLING AND INSURANCE

I understand that whether a patient have dental insurance or not, fees incurred are due when services are rendered, and they are entirely the patient's responsibility.

I understand the office might have available payment plans and/or financing options with third party Lenders to accommodate my payment for services. It is my responsibility as a patient to consult these options before any treatment or services are rendered.

INSURANCE

I understand that the office accepts some dental insurances and that when a patient has dental insurance, the patient must provide the information to the office to verify their insurance benefits. I understand that if a patient insurance grants coverage for services, then the patient needs to pay only a portion (also known as deductible or co-insurance) at the time of service.

I understand some providers in the office might not participate with my insurance plan and I will be notified of this before any services are rendered. I may have the opportunity to use my insurance benefits to be treated by an out-of-network provider if I choose to do so.

I understand that an insurance is a contract between the patient and the insurance company and that the office as a courtesy to their patients, and to help them maximize their insurance benefits can assist a patient in submitting a proposed treatment plan for preauthorization and/or submitting claims for services rendered to the patient's insurance company on behalf of the patient.

I understand the office will make every effort to facilitate this process but as a patient I remain ultimately responsible for the total bill. I understand that if for any reason the patient's insurance does not pay within 45 days for services rendered, then the balance is due payable in full at this time, by the patient.

Patient Name: _____

Patient or Legal Guardian Signature: _____ **Date:** _____