Welcome to Dr. Larry E. Krevitz's Office

Name_____ Nickname_____ M F

Address_____

City_____ _____State_____ Zip _____

Marital Status: Married__ Single__ Partnered_ Divorced_ Widowed__

Home Phone ( )_____ Work Phone ( )_____

Cell Phone ( )_____ E-Mail Address_____

Occupation:_____Employer:_____

Date of Birth: _____ SSN:_____

If Student- Name of school:_____

***_*Whom May We Thank For Referring You?*_ _____

In Case of Emergency, Whom Shall We Contact? Name_____
Phone # _____ Relationship_____
Person Responsible for Payment: Self___Other_____Name_____
Address_____Phone#_____

Dental Insurance Information

Primary Insurance	Secondary Insurance
Employee/Subscriber:	Employee/Subscriber:
Full Name_____	Full Name_____
Soc. Sec #_____	Soc. Sec. #_____
Date of Birth_____	Date of Birth_____
Employer	Employer
Name of Employer_____	Name of Employer_____
Phone_____	Phone_____
Group #_____	Group#_____
Insurance Co. Name & Address	Insurance Co. Name & Address
_____	_____

DR. LARRY E. KREVITZ
FAMILY & COSMETIC DENTISTRY

MEDICAL-DENTAL HISTORY

PATIENT NAME:_____ AGE:____ DATE OF BIRTH:_____

MEDICAL HISTORY

☐Y ☐N ARE YOU UNDER MEDICAL TREATMENT? FOR WHAT?_____
☐Y ☐N HAVE YOU HAD A MAJOR OPERATION? IF SO, WHAT?_____
☐Y ☐N ARE YOU ALLERGIC TO ANY MEDICATION?_____
☐Y ☐N ARE YOU ALLERGIC TO ANY FOODS? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

☐Y ☐N **MITRAL VALVE PROLAPSE**
☐Y ☐N **HEART MURMUR**
☐Y ☐N **HEPATITIS**
☐Y ☐N KIDNEY DISEASE
☐Y ☐N DIABETES
☐Y ☐N **RHEUMATIC FEVER**
☐Y ☐N **HIGH BLOOD PRESSURE**
☐Y ☐N **STOM/INTEST DISEASE**
☐Y ☐N HEART AILMENTS
☐Y ☐N LIVER DISEASE
☐Y ☐N LUNG DISEASE
☐Y ☐N BLOOD DISEASE
☐Y ☐N EPILEPSY
☐Y ☐N LOW BLOOD PRESS
☐Y ☐N ARTHRITIS/RHEUMATISM
☐Y ☐N **HEART ATTACK-YEAR:**_____
☐Y ☐N **STROKE-YEAR**____
☐Y ☐N **HIP/KNEE REPLACEMENTS-YEAR:**_____
☐Y ☐N **HIV TEST**/ DATE OF TEST:_____
☐Y ☐N CANCER/ TUMORS –TYPE_____
☐Y ☐N VENEREAL/STD

☐Y ☐N DO YOU HAVE A HISTORY OF ALCOHOL OR DRUG ABUSE?
☐Y ☐N ARE YOU PREGNANT?
☐Y ☐N DO YOU HAVE A HISTORY OF FAINTING?
☐Y ☐N IS THERE A MEDICAL CONDITION WE SHOULD BE AWARE ?_____

MEDICATIONS

☐Y ☐N ARE YOU TAKING MEDICATION? PLEASE LIST:_____
☐Y ☐N ARE YOU TAKING BIRTH CONTROL PILLS? TYPE:_____
☐Y ☐N ARE YOU TAKING NATURAL SUPPLEMENTS?_____ ☐Y ☐N DAILY ASPIRIN THERAPY?

PHYSICIAN'S NAME_____ **PHONE NUMBER** _____

PHARMACY NAME/ PHONE NUMBER_____

DENTAL HISTORY

☐Y ☐N DO YOU HAVE A SPECIFIC PROBLEM?_____
☐Y ☐N DO YOU HAVE PAIN IN YOUR EARS? ☐Y ☐N DO YOU CLENCH OR GRIND YOUR TEETH?
☐Y ☐N HAVE YOU HAD A REACTION TO NOVOCAINE?
☐Y ☐N DO YOUR GUMS BLEED? ☐Y ☐N HAVE YOU HAD ORAL HOME CARE /BRUSHING INSTRUCTIONS?
☐Y ☐N DO YOU SMOKE OR USE SMOKELESS TOBACCO?

WHEN WAS YOUR LAST COMPLETE X-RAY SERIES TAKEN?_____ WHERE?_____
WHEN WAS YOUR DENTAL CLEANING?_____ WHERE?_____

STAFF USE

MEDICATION	REASON	CHANGE	DATE	INIT	STAFF

CERTIFICATION: I CERTIFY THAT THE ANSWERS I HAVE GIVEN ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE:_____ **DATE:**_____ **STAFF INITIALS**_____

Dr Larry E Krevitz Family & Cosmetic Dentistry

Your Insurance Benefits & Office Billing Policy

We are very happy to accommodate our patients and accept benefits from your dental insurance carrier. In order to handle your claim as quickly as possible, please help us in the following ways:

***Please have all of your insurance information available for the office manager at the initial visit. If we are unable to process your claim you will be required to pay for your services; when the complete information is provided, we will process the claim for payment.**

***We are willing to accommodate our patients by waiting for your carrier's payment. However please be prepared to pay your portion of the treatment at the time of service. For your convenience we accept major credit cards and personal checks.**

There is a finance charge of 1.5% per month, or 18% per year, for personal balances after insurance coverage is determined, unless payment arrangements are made in advance of dental care.

If you have any questions please feel free to ask our staff for assistance.

I understand the office policy regarding insurance coverage and open balance charges. I further understand that I am responsible for all incurred expenses, regardless of insurance coverage.

_____ _____

Signature **Date**

Appointment Policy

In our effort to provide the best in dental care, we want to be able to give you the first available appointment, and to see you on time. In order to accomplish these goals, as well as to complete your dental care, it is important that all appointments be honored.

In the event that it becomes necessary to change your appointment, please provide us at least 24 hours' notice.

To discourage those that would inconvenience others by not honoring their appointments, we have instituted an appointment time fee of $25 per half hour. This charge is for those who fail to honor their appointments without cause. Your understanding is appreciated.

I understand that I may be responsible for charges for missed appointments without cause.

_____ _____

Signature **Date**

LARRY E. KREVITZ, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: patient giving consent

NAME: _____

ADDRESS: _____

TELEPHONE: _____

Section B: *to the patient, please read the following statements carefully*

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of privacy practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact person: Dawn MacDonald, office manager

Telephone: 215-674-2505 **Fax:** 215-674-2953

Address: 121 North York Road Suite 11 Hatboro, Pa. 19040

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to patient: _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

√ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (e.g. a theater or a meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Total Score: _____
(Add columns 0-3)

Patient Signature _____ Date _____

Larry E Krevitz, DDS PC

Family & Cosmetic Dentistry

In an effort to streamline billing and add convenience to our patients, we are now securely recording your credit card information to clear your balances after insurance payment.

I authorize Dr. Larry E Krevitz, DDS PC to keep my signature on file and to charge my credit card for charges not paid by my insurance carrier.

Maximum Amount : ☐ $100 ☐$250 ☐No Limit

Patient: _____

Family Members:

_____

☐ Visa ☐Mastercard ☐ Discover ☐ American Express
☐ Care Credit

Cardholder: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Account #: _____

Expiration Date: _____ CVV _____

Cardholder Signature: _____

Date: _____