JEANNE ANNE KRIZMAN, DMD, PLC
1601 N. TUCSON BLVD, SUITE #35
TUCSON, ARIZONA 85719
(520) 326-0082

Date: _____
Name: _____

Thank you for selecting us as your dental care provider. Who may we thank for referring you to our office?_____

PATIENT INFORMATION

Last Name_____ First Name_____

Middle Initial _____ Title _____ Preferred Name_____

Marital Status _____

Birth Date_____/_____/_____

Street Address_____

City_____ State_____ Zip Code _____

Indicate preferred contact

Home Phone (_____)_____-_____ _____

Cell Phone (_____)_____-_____ _____

Email_____ _____

Occupation _____ Employer _____

Employment Address_____

Work Phone (_____)_____-_____

Emergency Contact _____

Emergency Phone (_____)_____-_____

Relationship to Patient _____

MEDICAL INFORMATION

Have you been a patient in the hospital during the past two years? Yes No
Have you been under the care of a medical doctor during the past two years for a specific condition?
Yes No
Date of most recent medical exam:_____
Physician's Name_____
Physician's Address (if known)_____

Please list any medication or drugs you are taking, including prescription medications, over the counter medications, herbal or holistic remedies, vitamins minerals, etc.

Please list any medications (antibiotics) or anesthetics to which you are allergic.

Does your physician recommend that you pre-medicate prior to dental treatment? Yes No

Do you have or have you had any disease, condition or problem **NOT** listed on the previous page?

Yes No

If YES, please identify:

Did you take the diet drug Fen-Phen that is no longer on the market? Yes No

Do you have any disease, that are you taking any medication/ drugs, or have you had any transplant operation that has or may have depressed your immune system? Yes No

Do you have a history of any of the following:

Alcohol or chemical dependency? Yes No

Emotional disorder? Yes No

Developmental disability that may have an impact
on your needs or on the care we provide you? Yes No
Do you fear dental work? Yes No

Ideally, is there anything you wish to change about the appearance of your smile (i.e. discolored teeth or filling, crooked or crowded teeth, gaps in your teeth, missing teeth, too small or too large of teeth?) Yes No

If yes, please explain:_____

For Women: Are you pregnant? Yes No Due date_____

Are you nursing? Yes No

Are you taking birth control pills? Yes No

- If you are using non-mechanical contraceptives, antibiotics may interfere with their effectiveness. Consult your physician; you may wish to use mechanical forms of birth control for one full cycle after completion of antibiotic treatment.

Patient Printed Name: _____

Please indicate if you've had or have any of the following. **Circle "YES" or "NO" for each.**

MEDICAL HISTORY

Heart Disease	Yes	No	Tumors	Yes	No
Heart Attack	Yes	No	Cancer	Yes	No
Heart Surgery	Yes	No	Radiation Therapy	Yes	No
Heart Murmur	Yes	No	Chemotherapy	Yes	No
High Blood Pressure	Yes	No	Emphysema	Yes	No
Arteriosclerosis	Yes	No	Asthma	Yes	No
Mitral Valve Prolapse	Yes	No	Nervousness	Yes	No
Heart Pacemaker	Yes	No	Anorexia/ Bulimia	Yes	No
Respiratory Problems	Yes	No	Hemophilia	Yes	No
Angina Pectoris	Yes	No	Chronic Cough	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No
Stroke	Yes	No	Seasonal Allergies	Yes	No
Arthritis	Yes	No	Easily Bruise	Yes	No
Artificial Joints	Yes	No	Ulcers	Yes	No
HIV / AIDS	Yes	No	Nausea	Yes	No
Hepatitis A (infectious)	Yes	No	Dizzy Spells/ Fainting	Yes	No
Hepatitis B (serum)	Yes	No	Loss of Hearing	Yes	No
Hepatitis C	Yes	No	Tension Headaches	Yes	No
Liver Disease	Yes	No	Migraine Headaches	Yes	No
Kidney Disease	Yes	No	Severe Blow to Head	Yes	No
Anemia	Yes	No	Whiplash Injury	Yes	No
Thyroid Problems	Yes	No	Seizures / Epilepsy	Yes	No
Diabetes	Yes	No	Take Blood Thinners	Yes	No
Chemical Sensitivities	Yes	No	Tobacco Use	Yes	No
Mold Toxicity	Yes	No	MTHFR Gene Mutation	Yes	No

DENTAL HISTORY

Bleeding Gums	Yes	No	Wear Night Guard	Yes	No
History of Deep Cleanings	Yes	No	Chronic Facial Pain	Yes	No
Difficulty Opening Wide	Yes	No	Pain in Jaw Joint	Yes	No
Clench Teeth	Yes	No	Cold Sores	Yes	No
Wisdom Teeth Extracted	Yes	No	Mouth Ulcers	Yes	No

ALLERGIES

Penicillin	Yes	No	Latex	Yes	No
Codeine	Yes	No	Dental Anesthetics	Yes	No

Patient Printed Name: _____

Do you have any disease, condition or problem NOT listed above? Yes No

If YES please explain:

Vitals: BP: _____ HR:_____ (Staff to complete)

Consent:

1. I understand that the above information is necessary for the doctor to provide me with comprehensive dental care in a safe manner. I have answered all questions truthfully and to the best of my knowledge.

2. I authorize Dr. Krizman to take radiographs and photographs, make study models, or employ other diagnostic aids deemed appropriate for the purpose of making a thorough diagnosis of my dental needs. Unnecessary radiographs will not be taken.

3. I authorize Dr. Krizman to perform all recommended treatment with which I have agreed, and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.

4. I authorize the release of examination findings, diagnosis, treatment program, etc., to my referring or treating dental specialists and/or physicians.

5. I understand that all responsibility for payment for dental services provided in this office for myself and/ or for my dependents is mine, due and payable at the time services are rendered, unless other arrangements have been made.

6. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

7. If I am 18 years of age or older and if my parents/guardians are my guarantors, I give permission for Dr. Krizman to place a phone call to my parents'/guardians' home regarding account balances, and/or account credits and/or to mail statements or other information to my parents'/ guardians' home address regarding account balances, and/or account credits.

8. Provided that my name is not revealed, Dr. Krizman may use study models, radiographs, and photographs of my mouth in lectures or seminars in which the doctor conducts.

Patient Printed Name: _____

Patient Signature_____ Date _____

OR

Signature of Parent or Responsible Party_____ Date_____

Relationship to Patient_____

HIPAA NOTICE OF PRIVACY PRACTICES

JEANNE ANNE KRIZMAN, DMD, PLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEAE REVIEW IT CAREFULLY.

This Notice of privacy practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, “TPO,” and for other purpose that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information," or “PHI,” is information about you including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

General: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to another physician to whom you have been referred ensure that the physician has the necessary information to diagnose or treat you or to a home health agency that provides care to you or as required.

Payment: Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to dental school students or interns that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you, we may use or disclose your protected health information, as necessary, to contact you of your appointment.

DISCLOSURE

Disclosure Required by Law: We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law, matters public health issues, communicable diseases, health oversight, abuse or neglect; Food and Drug Administration requirements; legal proceedings; matters concerning law enforcement, coroners, funeral directors, and organ donation; medical/dental research; criminal activity; military activity and national security; workers' compensation matters; and inmates required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with the respect to your protected health information:

You have the right to Inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following: psychotherapy notes; information compiled in reasonable anticipation of or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to a law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations.

You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Health care Professional.

You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made. if any, of your protected health information.

We reserve the right to change the terms of this of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 5, 2014.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by the phone at our main telephone number.

RECEIPT

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient Printed Name: _____

Signature: _____ Date: _____

FINANCIAL POLICY

JEANNE ANNE KRIZMAN, DMD, PLC

Thank you for choosing our office for you dental needs. We are committed to provide the highest quality of dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer you options for payment. The following is a statement of our Financial Policy which must be reviewed and signed.

INSURANCE

As a courtesy, our office will provide you with the proper dental codes so that you may submit your insurance claims independently. Our patients generally receive reimbursement from their insurance carriers in 2-3 weeks. We are out-of-network providers and therefore have no connection to your insurance plan.

PAYMENT

PA YMENT IS DUE WHEN SERVICES ARE BEING RENDERED. Ours is a small office and we depend on our patients paying the agreed fee when services are rendered. If you cannot pay at the time that service is rendered, you must make alternate arrangements acceptable to us before treatment begins.

PAYMENT OPTIONS

We offer the following payment options:

Cash or Check Payment.
Visa, Master Card, American Express, Discover, Debit.
No Interest Payment Plan with Care Credit (OAC). If you intend to pay by OAC, you must make arrangements acceptable to us before treatment begins.

RETURNED CHECKS

A $25.00 returned check fee will be billed for any returned checks.

ACKNOWLEDGMENT

Thank you for understanding our Financial Policy. We are here to assist you in any way possible. Please make your questions and concerns known to our team as our goal is to ensure that you have an outstanding experience. I have read the Financial Policy. I understand and agree that:

I understand that my insurance is a contract between me and my insurance company and that Jeanne Anne Krizman DMD, PLC does not file insurance claims for you. I understand that Dr. Krizman is not in network with my insurance and authorize payment from my insurance will be paid directly to me. I understand that Jeanne Anne Krizman DMD, PLC is a fee for service dental-care provider. I understand that insurance is not a guarantee of payment.

Patient Printed Name: _____

Signature of Patient/Responsible Party:_____ Date:_____

PATIENT APPOINTMENT POLICY

Dear Valued Patient,

Our purpose is to help our patients keep their teeth and gums healthy for life. Proper scheduling of appointments is vital to this endeavor. Therefore, we ask for your cooperation regarding the following appointment policy:

1.) Every effort is made to keep on schedule so we respectfully ask patients to be prompt and keep their appointments. We try to remind patients by telephone prior to their appointment, but please do not depend on this courtesy. If we are unable to reach you, your appointment card/invoice printout will serve as the confirmation of your appointment and implies your obligation and agreement to be present at the appointed time. That time has been reserved especially for you. This means no other patient has been scheduled for that particular time slot and chair, and that anyone else wishing to schedule for that time has had to be given a different time for their appointment. We reserve the right to charge for office visits cancelled or broken with less than 2 business days advance notice (e.g. if your appointment is scheduled for Monday at 3 P.M., and you need to re-schedule, you must call us before the prior Thursday at 3 P.M.). Exceptions to this policy can be determined only on an individual basis according to the circumstances. The broken appointment charge will depend on the procedure and time reserved, but will start at $50 per hour for the hygienist and $100 per hour for the doctor.

2.) In order to ensure that we keep to our schedule, and yours, as much as possible and to minimize patient waiting time, it is necessary to schedule certain procedures for specific times during the day. This allows us to provide you with the excellence in care that you expect and deserve. We know that your time is valuable and that none of our patients want to spend any longer in the dentist's office than they have to. Scheduling specified procedures for specific time slots allows us to be more efficient with your treatment and actually minimizes the time you have to spend at our office.

If you have any questions about this policy, do not hesitate to ask our office staff. We believe that good communication is key to providing you with quality dental care.

Patient Printed Name: _____

Patient Signature: _____ Date _____

OR

Signature of Parent or Responsible Party_____ Date_____

Relationship to Patient_____