Mr Ms Mrs Dr

First Name MI Last Name

Date of Birth SSN Occupation

Address Mobile Phone

City State Zip Home Phone

ER Contact ER Phone Work Phone

Employer Email

Dentist Referred by

Primary Dental Insurance

Address

City State Zip

Group Phone

Employer

Employee's Name

Employee's DOB SSN

Secondary Dental Insurance

Address

City State Zip

Group Phone

Employer

Employee's Name

Employee's DOB SSN

Privacy Notice, Authorization for Release of Protected Health Information (PHI) and Signature on File:
Dr. Kiurtsidis and his representatives follow state and federal laws to safeguard patient's privacy. I authorize Dr. Kiurtsidis, or his representatives, to release to health care providers and/or health service plans and insurance companies any and all information and records (including x-rays) about my medical history, services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits. I also authorize Dr. Kiurtsidis to affix my name to any and all claims or documents related to any and all health benefits. If my coverage requires it, this authorization permits disclosure to appropriate entities for purposes of utilization review or financial audit. By signing this registration form, I acknowledge that I have either received or accessed Privacy Notice at http://myperio.com/privacy.html. I have the right to receive a paper copy of this authorization and Privacy Notice disclosing how Dr. Kiurtsidis and his representatives may use or disclose PHI, if requested.

Cancellations & Service Charges:
All appointment changes require 2 day notice. In the case of default payment or no show, I promise to pay 1.5% a month interest on the balance due, together with any costs and fees incurred to effect collection.

Payment:
I authorize Dr. Kiurtsidis's office to assist me in obtaining my dental insurance benefits. I understand that my dental insurance is a contract between me, my employer and the insurance carrier. Regardless of the expected or implied insurance benefits, I am ultimately responsible for the entire balance of my account. All balances be paid in full at the time of the treatment. As a courtesy, Dr. Kiurtsidis' office will process insurance claims on my behalf and insurance reimbursements will be made directly to me.

Signature Date

Physician's Name

Address

Phone Fax

Last Exam Height Weight Age

Current treatment for

Always report changes in health as soon as possible.

Y N Check any *past* or *current* **medical** conditions:

- Abnormal bleeding
- Anemia
- Asthma
- Arthritis
- Blood transfusion
- Cancer/Chemotherapy/Radiation/IV Bisphosphonate
- Diabetes
- Diet pills Fen-Phen, Redux, Pondimin
- Difficulty breathing/Chest pains
- Drug/Alcohol abuse
- Emphysema
- Epilepsy/Seizures
- Fainting spells
- Fever blisters
- Glaucoma
- Heart arrhythmia
- Heart disease
- High blood pressure BP Pulse
- Low blood pressure
- Heart murmur/Mitral valve prolapse/Rheumat. fever
- Heart surgery/Pacemaker
- Hepatitis
- Herpes
- HIV+/AIDS
- Hospitalization
- Joint replacement
- Kidney problems
- Liver problems
- Neck/Back/Joint problems
- Psychiatric problems
- Severe headaches
- Shingles
- Sinus problems
- Skin problems
- Stroke
- Surgeries
- Tobacco use /day for years Status
- Tachycardia
- Thyroid problems
- Tuberculosis
- Ulcers/Colitis
- Venereal disease
- Women: Pregnant/Nursing
- Women: Birth control pills

Dentist's Name

Address

Phone Fax

Last Exam Last Cleaning Frequency

Current treatment for

I brush I floss Toothbrush

Y N Check any past or current **dental** conditions:

- Bad breath
- Bleeding gums
- Dry mouth
- Infection in mouth
- Interested in dental implants
- Jaw problems
- Loose teeth
- Nervousness during dental treatment
- Orthodontic treatment (braces, Invisalign)
- Pain/Discomfort related to mouth
- Receding gums
- Scaling & Root planing (deep cleaning) M/Y
- Sensitive teeth to cold, hot, sweet, etc.
- Spaces between the teeth
- Surgical periodontal treatment M/Y

Have you been told by your physician to take **antibiotics** prior to having dental treatment?

Are you **allergic** to any of the following:

- Amoxicillin/Penicillin
- Aspirin/Advil/Motrin
- Codeine
- Erythromycin
- Latex
- Sulpha
- Tetracycline
- Other

Other conditions and concerns not mentioned above:

List all medications & over-the-counter products:

Notes

Signature Date Reviewed by: