FINANCIAL POLICY

Our office is committed to providing excellent, affordable dental care. You have the right and responsibility to know the cost of your dental treatment. If you have dental insurance, and even if we bill your insurance company directly, you may be responsible for co-payment, coinsurance, deductible, and non-covered amounts. For your convenience, our office accepts personal checks, credit cards, cash, Care Credit, and Lending Club.
Please read carefully, as it outlines our financial policy.

It is important that insurance patients understand how insurance billing works. Insurance companies require us to break down every component of your office visit into universal, numerical procedure codes, and charge for each code. The insurance companies will arbitrarily change, combine, or disallow procedure codes, and then apply their company's individual fee schedule. The result is the insurance company's determination of "reasonable and customary" changes – the amount they are willing to cover. The insurance company usually reduces the actual reimbursement further by the individual policy's annual deductible, co-payment or coinsurance.

This method of billing, designed by the insurance industry, forces us to bill at full price procedure codes that the insurance company will likely reduce, combine, or simply deny. This system, in fact, has the insurance company determining the fees. If we have a contract with your insurance company, we write-off the amount over the "reasonable and customary", and bill you for coinsurance and deductible. If we do not have a contract with your insurance carrier, you are responsible for that amount as well as any deductible and coinsurance.

We are required by all insurance carriers to collect from patients any deductible and co-payment or co-insurance amounts. In the unlikely event you stop payment, are notified of Insufficient Funds or your account is turned over to Collections, you will be responsible for all related costs.

I have read and understand Kudlik Dental Corporation financial policy as outlined above. The following constitutes an agreement between the undersigned patient/guarantor and Kudlik Dental Corporation.

In the event Kudlik Dental Corporation agrees to seek payment initially from my insurance company, I request payment to be made directly to them and all dental benefits otherwise payable to me for service rendered. I understand any final obligations for payment are mine. Any portions of my bill not paid by insurance are my responsibility and are due and payable upon demand. I hereby authorize Kudlik Dental Corporation to release all information necessary to secure payment of benefits.

NAME (please print)_____

SIGNATURE_____ DATE_____

WITNESS_____ DATE_____

For Patients with Dental Insurance:

2019 Dental Insurance Changes and Law Disclaimer

Dear Valued Patient,

We are a PPO and CASH provider only. There are many new insurance changes that we cannot verify due to high volume of phone calls. We will bill insurance as a courtesy to our patients and it is the responsibility of the patient to be aware of any policy changes. You will be responsible for you deductible, co-payment, and coinsurance if applicable. Please speak to the billing office or Office Manager with any questions or concerns.

Insurance Disclaimer – A quote of benefits and/or authorization does not always guarantee payment of verified eligibility. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract with their insurance company at the time of service.

Insurance Liability of Payment – Your health insurance company will not pay for services that it does not determine to be "reasonable and necessary under your agreed health plan." Every effort will be made by our office to have all services and procedures covered by your health insurance company. If your health insurance company determines that a service is not a covered benefit under your plan, the patient then becomes responsible for the amount due.

Beneficiary Agreement – I understand that my health insurance company may deny payment for the services identified above for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does not make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Sincerely,

Dennis Kudlik, DDS

Sign Here to assign benefits to Kudlik Dental Corporation

NAME (please print)_____

SIGNATURE_____ DATE_____

WITNESS_____ DATE_____

Primary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ ID/SSN# : _____ Group #: _____

Insured's Address: _____ _____
Street Address Apt/Unit #

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Street Address Suite/Unit #

_____ _____ _____
City State Zip Code

Patient's relationship to the insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Street Address Suite/Unit #

_____ _____ _____
City State Zip Code

Secondary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ ID/SSN#: _____ Group #: _____

Insured's Address: _____ _____
Street Address Apt/Unit #

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Street Address Suite/Unit #

_____ _____ _____
City State Zip Code

Patient's relationship to the insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Street Address Suite/Unit #

_____ _____ _____
City State Zip Code

Kudlik Dental Corporation
BiologicallyFriendlyDentistry@gmail.com
www.BiologicallyFriendlyDentistry.com

Medical History

Patient Name: _____ Date of Birth: _____ Age: _____
Gender: **O** Male **O** Female
How would you describe your health? **O** Excellent **O** Good **O** Fair **O** Poor
Has there been any change in your general health within the past year? **O** Yes **O** No
If yes, please explain: _____
Are you under the care of a physician? **O** Yes **O** No
Name of physician and their specialty: _____
Your most recent physical exam was within the last: **O** year **O** 2 years **O** 3+ years
Do you have any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment? **O** Yes **O** No
If yes, please describe: _____
Have you had any serious illness, operation, or been hospitalized in the past 5 years?
O Yes **O** No
If yes, what was the illness or problem? _____

Are you currently taking any Antibiotics? **O** Yes **O** No
If yes, please explain: _____
Are you taking birth control pills? **O** Yes **O** No
Are you pregnant or nursing? **O** Yes **O** No
Are you taking/have you taken oral/IV bisphophonates, including alendronate (Fosamax) & risedronate (Actonel)? **O** Yes **O** No
Do you take blood thinners (i.e. Coumadin)**?** **O** Yes **O** No
Are you taking any medication(s) including non-prescription medication (other than the above mentioned)? **O** Yes **O** No
If yes, what medication(s) are you taking? _____
_____
Are you taking any supplements and/or vitamins? **O** Yes **O** No
If yes, what supplements/vitamins are you taking? _____
_____
Are you allergic or have you ever had a reaction to any of the following? (Check all that apply)

Local Anesthetics	**O** Yes	**O** No	Iodine	**O** Yes	**O** No
Penicillin or other antibiotics	**O** Yes	**O** No	Latex	**O** Yes	**O** No
Codeine or other narcotics	**O** Yes	**O** No	Hay Fever/Seasonal	**O** Yes	**O** No
Barbiturates or sedatives	**O** Yes	**O** No	Animals: _____	**O** Yes	**O** No
Sulfa drugs	**O** Yes	**O** No	Food: _____	**O** Yes	**O** No
Aspirin	**O** Yes	**O** No	Other: _____	**O** Yes	**O** No
Metals: _____	**O** Yes	**O** No			

If yes, please explain reaction(s): _____

Do you have or have you ever had any of the following diseases or problems? (Check all that apply)

Artificial heart valves	**O** Yes	**O** No
History of infective endocarditis	**O** Yes	**O** No
Heart transplant with Problematic valve	**O** Yes	**O** No
Congenital Heart Disease (CHD)	**O** Yes	**O** No
Heart attack	**O** Yes	**O** No
Heart Bypass/Stent Surgery	**O** Yes	**O** No
Angina	**O** Yes	**O** No
Congestive heart failure	**O** Yes	**O** No
High blood pressure	**O** Yes	**O** No
Low blood pressure	**O** Yes	**O** No
Arteriosclerosis	**O** Yes	**O** No
Stroke/TIA/Mini-stroke	**O** Yes	**O** No
Pacemaker	**O** Yes	**O** No
Damaged heart valves (including heart murmur or rheumatic heart disease)	**O** Yes	**O** No
Asthma	**O** Yes	**O** No
Bronchitis, COPD, emphysema	**O** Yes	**O** No
Sleep Apnea	**O** Yes	**O** No
Sinus trouble	**O** Yes	**O** No
Tuberculosis	**O** Yes	**O** No
Persistent cough (more than 3 weeks)	**O** Yes	**O** No
Cough that produces blood	**O** Yes	**O** No
Exposed to anyone with tuberculosis	**O** Yes	**O** No
Kidney trouble	**O** Yes	**O** No
Abnormal bleeding	**O** Yes	**O** No
Blood disorders (such as anemia)	**O** Yes	**O** No

Prosthetic joints (ie. knee, hip)	**O** Yes	**O** No
Arthritis or painful swollen joints	**O** Yes	**O** No
Cancer	**O** Yes	**O** No
Radiation therapy	**O** Yes	**O** No
Chemotherapy or Immunotherapy	**O** Yes	**O** No
Difficulty/slow healing, prone to infections	**O** Yes	**O** No
Diabetes	**O** Yes	**O** No
Frequent urination	**O** Yes	**O** No
Excessive thirst	**O** Yes	**O** No
Unexpected weight gain/loss	**O** Yes	**O** No
Persistent diarrhea/constipation	**O** Yes	**O** No
GERD/Reflux/Ulcers/Heartburn	**O** Yes	**O** No
Frequent Vomiting	**O** Yes	**O** No
Headache	**O** Yes	**O** No
Organ transplant	**O** Yes	**O** No
Problems of the immune system	**O** Yes	**O** No
AIDs or HIV infection	**O** Yes	**O** No
Hepatitis, jaundice, or liver disease	**O** Yes	**O** No
Sexually transmitted diseases	**O** Yes	**O** No
Thyroid problems	**O** Yes	**O** No
Epilepsy/seizures/fainting spells	**O** Yes	**O** No
Memory issues/Dementia/ Alzheimer's	**O** Yes	**O** No
Generalized Anxiety	**O** Yes	**O** No
Problems with mental health	**O** Yes	**O** No
Chronic fatigue	**O** Yes	**O** No
Are you wearing contact lenses?	**O** Yes	**O** No

If any conditions or alerts selected above need further clarification, please describe:_____

_____

_____

Do you have any disease, condition, or problem not listed above that you think we should know about? **O** Yes **O** No

If yes, please explain: _____

_____

_____

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 the providers at Kudlik Dental Corporation will rely on this information for treating me / my child. I understand that it is my responsibility to inform the office of any changes in my/my child's health as soon as possible.

_____ _____

Patient or Parent/Guardian Signature Date Provider Signature Date

Kudlik Dental Corporation
BiologicallyFriendlyDentistry@gmail.com
www.BiologicallyFriendlyDentistry.com

Dental History

Patient Name:_____ Date of Birth:_____ Age:_____

Your honest and thoughtful answers are appreciated and help us to offer you a treatment plan tailored to your individual needs and desires**.**

What is your immediate concern/ Reason for your visit today?_____

_____

_____

Previous Dentist name and how long you have been a patient there:_____

_____

Date of most recent dental exam:_____ Date of most recent dental x-rays:_____

I routinely see my dentist every: **O** 3 months **O** 4 months **O** 6 months **O** 12 months **O** Not routinely

How would you rate the condition of your mouth? **O** Excellent **O** Good **O** Fair **O** Poor

How fearful of dental treatment are you on a scale of 1(least) to 10 (most)?_____

Have you had any serious trouble or complications with any previous dental treatments?

O Yes **O** No

If yes, please explain:_____

_____

How many times/day do you brush your teeth? **O** Not daily **O** 1x/day **O** 2x/day **O** 3x+/day

How many days/week do you floss? **O** Never **O** Only when food gets stuck **O** 1-3x/week **O** 4-6x/week **O** Everyday

List any other medicaments or devices you use in your oral hygiene routine at home (ie. mouthwash, baking soda, MI Paste, toothpicks, prox-brushes, electric toothbrush, Waterpik):_____

_____

Alcohol use: **O** Never **O** Occasionally **O** Daily

Tobacco use: **O** Never **O** Past **O** Current

If tobacco use (past/current), what form, how much/day, how long in years: _____

_____

Personal History - Please check all that apply:

O Had an unfavorable dental experience
O Had/have braces, orthodontic treatment
O Wears orthodontic retainer
O Had any teeth removed
O Wears dentures or partials
O Had any reactions to local anesthetic
O Had trouble getting numb
O Had your bite adjusted
O Participate in active recreational sports activities
O Had a serious injury to head or mouth

If any of the checked boxes need further explanation, please describe:_____

_____

Smile Characteristics - Please check all that apply:
O Is there anything about the appearance of your teeth that you would like to change?
O Have you ever whitened (bleached) your teeth?
O Have you ever felt uncomfortable or self-conscious about the appearance of your teeth?
O Have you been disappointed with the appearance of previous dental work?
If any of the checked boxes need further explanation, please describe:_____

Bite and Jaw Joints - Please check all that apply:
O You have had problems with your jaw joints (i.e. clicking, popping, discomfort)
O You have problems chewing
O Your teeth changed in the last 5 years, become shorter, thinner, or worn
O Your teeth crowding or developing spaces
O You clench your teeth in the daytime or make your jaws or teeth sore
O You've had your bite adjusted
O You grind your teeth (daytime or nighttime) or have been told you do
O You wear or have worn a bite appliance
O You wake up with headaches, neck pain, earaches, or an awareness of your teeth
O You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
If any of the checked boxes need further explanation, please describe:_____

Tooth Structure - Please check all that apply:
O Cavities within the past 3 years
O The amount of saliva in your mouth seems too little or you have difficulty swallowing your food
O Any teeth feel sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
O Grooves, holes, or notches on your teeth, chipped teeth, or had a toothache or cracked filling
O Food gets routinely caught between any teeth
If any of the checked boxes need further explanation, please describe:_____

Gum and Bone - Please check all that apply:
O Gums bleed when brushing or flossing
O Treated for gum disease or were told you have lost bone around your teeth
O Noticed an unpleasant taste or odor in your mouth
O Experienced a burning sensation in your mouth
O History of periodontal disease in your family
O Have any sores or ulcers in your mouth
O Had any teeth become loose on their own (without injury), or have difficulty eating an apple
If any of the checked boxes need further explanation, please describe:_____

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 the providers at Kudlik Dental Corporation will rely on this information for treating me/my child. I understand that it is my responsibility to inform the office of any changes in my/my child's health as soon as possible.

Patient or Parent/Guardian Signature Date

Provider Signature Date

Sleep Disorder Questionnaire

Patient Name: _____ Date: _____

- OVER 18 MILLION AMERICANS SUFFER FROM SLEEP APNEA
- PEOPLE WITH SLEEP APNEA ARE 3 TIMES MORE LIKELY TO BE INVOLVED IN MOTOR VEHICLE ACCIDENTS
- 90% OF SLEEP APNEA PATIENTS HAVE NOT BEEN DIAGNOSED

Do you snore?	Yes	No
Do you have high blood pressure?	Yes	No
Have you gained weight and find it difficult to lose?	Yes	No
Do you have unexplained awakenings from sleep?	Yes	No
Do you awaken from sleep gasping for air or choking?	Yes	No
Do you notice frequent twitching or jerking of legs while asleep? Do you feel your sleep is not refreshing or restful?	Yes	No
Do you have a headache upon waking in the morning?	Yes	No
Do you often lay in bed unable to fall asleep?	Yes	No
Do you wake up during the night and are unable to fall back asleep? Do you feel fatigued or find it difficult to stay awake during the day?	Yes	No

Prior Diagnosis:

Have you been previously diagnosed with sleep apnea?		Yes	No
If Yes:	Approximately, when were you diagnosed?	_____	
	Were you put on CPAP therapy for treatment?	Yes	No
	Are you still using your CPAP every night?	Yes	No

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = Never doze off, 1 = slight chance of dozing, 2 = Moderate chance of dozing, 3 = High chance of dozing

Sitting and reading _____

Watching T.V. _____

Sitting inactive in a public place _____

As a passenger in a car for an hour without a break _____

Lying down to rest in afternoon _____

Sitting and talking to someone _____

Sitting quietly after lunch without alcohol _____

In a car, while stopped for a few minutes in traffic _____

Total Score : _____