Robert T. Kroepel, Jr., D.M.D., P.C.
GENERAL DENTISTRY AND SLEEP CARE

HEALTH HISTORY

DATE:

NAME: TITLE _____ LAST_____FIRST _____ MI ____ SUFFIX _____

MAILING ADDRESS

CITY, STATE ZIP CODE

BEST TELEPHONE H / W / M / OTHER

SECONDARY TELEPHONE H / W / M / OTHER

EMAIL

DOB _____ / _____ / _____ AGE SSN# _____ -- ____ -- _____ (REQUIRED) GENDER M / F

MARITAL STATUS S / M / D / W / OTHER: *(circle)* EMPLOYED/ UNEMPLOYED / STUDENT

SPOUSE NAME (if married) or PARENT /GUARDIAN NAME (if minor) EMPLOYER:

SPOUSE / PARENT TELEPHONE OCCUPATION:

H / W / M / OTHER *or* SCHOOL:

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT? SELF / OTHER HOW DID YOU FIND US?

(If other) NAME RELATONSHIP Website / Online Search / Referred / Other:

DOB _____ / _____ / _____ SSN# _____ -- ____ -- _____ (REQUIRED) Whom may we thank for referring you?

PRIMARY PHYSICIAN NAME: Date of last physical (approx.)

PREVIOUS DENTIST OR PERIODONTIST: Date of last visit (approx.)

ADDRESS: HAVE YOU HAD RECENT DENTAL X-RAYS?

Have you experienced any of the following? Please "X" to the right and explain** below.

ALLERGIES TO DRUGS*	Y N	DEPRESSION	Y N	HIGH BLOOD PRESSURE	Y N	STROKE	Y N
ANXIETY	Y N	DEVELOPMENTAL DELAY**	Y N	LOW BLOOD PRESSURE	Y N	SWOLLEN NECK GLANDS	Y N
ARTHRITIS	Y N	DIABETES	Y N	IMMUNE DISORDER**	Y N	TOBACCO USE	Y N
ARTIFICIAL HEART VALVES	Y N	GASTROINTENSTINAL ISSUES	Y N	INTELLECTUAL DELAY**	Y N	THYROID DISORDER	Y N
ARTIFICIAL JOINTS/PINS**	Y N	GERD/ACID REFLUX	Y N	NERVOUS SYSTEM DISORDER	Y N	**Have you had a sleep study?**	Y N
BACK OR NECK PROBLEMS	Y N	GENERAL ALLERGIES	Y N	RADIATION TREATMENT	Y N	Do you have a CPAP?	Y N
BLOOD DISEASE	Y N	HEADACHES	Y N	RESPIRATORY DISEASE	Y N	If yes, do you use it?	Y N
CANCER	Y N	HEART PROBLEMS	Y N	SEIZURE DISORDER	Y N	**Females:**	
CHEMICAL DEPENDENCY	Y N	HEMOPHILIA	Y N	SNORING	Y N	Are you pregnant?	Y N
CIRCULATORY PROBLEMS	Y N	HEPATITIUS/LIVER DISEASE	Y N	SLEEP APNEA	Y N	Are you breastfeeding	Y N

*LIST ANY DRUG ALLERGIES : (do not abbreviate)

** EXPLAIN ANY "YES" ANSWERS ABOVE, IF NEEDED:

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (Please list)

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for errors or omissions that I may have made in the completion of this form.

Signature:_____ Date: _____

Insurance	**Secondary Dental Insurance?**
Primary Insured(Policy Holder):	Primary Insured(Policy Holder):
Name:	Name:
Address:	Address:
City, State Zip	City, State Zip
DOB (Required): SS# (Required):	DOB (Required): SS# (Required):
(Circle) Self -Insured or Through Employer:	(Circle) Self -Insured or Through Employer:
Insurance Company:	Insurance Company:
Group #: Member #:	Group #: Member #:

OR _____I do not have insurance coverage (or one the office participates in) and understand that payment is expected at the time of service unless previous payment arrangements have been made. *(Please see the front desk for fees and payment options.)*

I agree to provide the office with any proof of insurance and a photo ID; that Dr. Kroepel does NOT participate in any HMO/DHMO plans or Connecticut state Medicaid insurance; I understand I am responsible for knowing what my insurance will and will not cover and that any self-pay treatments or estimated out-of-pocket co-payments are due at the time of service and remaining balances not covered by insurance are my responsibility; I acknowledge that my signature is on file for insurance purposes.

Signature of patient or guardian:_____

Printed Name:_____ Date: _____

Acknowledgement Of Receipt of Privacy Practices

Our privacy policy is posted in our waiting room or a copy can be provided to you on request. You have the right to refuse to sign this form.

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature of patient or guardian:_____

Printed Name:_____ Date: _____

Office Use Only: An attempt was made to obtain written acknowledgement of receipt of our privacy services, but this could not be obtained because:

___Patient refused to sign ___Communication barriers prohibited acknowledgment ___An emergency situation prevented us from obtaining acknowledgement __Other

Office Policy Acknowledgement

These policies help keep time available and costs down for all our patients, including you! We appreciate your cooperation.

Payment of services: The patient is responsible for payment in full **at the time of service,** including any out-of-pocket estimates with co-insurance. We accept cash, personal checks, credit cards, debit cards, HAS/FSA cards and CareCredit. We will bill insurance any balance and any difference in the estimated co-pay or unused deductible will be credited or billed to your account as needed. If you have a large procedure coming up we are happy to discuss payment arrangements or free financing that we accept to be sure you can afford the care you need.

Broken or Canceled Appointments: The doctor and clinicians put aside time just for you to give you their full attention, so we require a **full business day notice** for changes and cancellations of your appointment time. Our business hours/days are Monday-Thursday from 7:30 AM to 5:00 PM, messages left on our voicemail after closing will not be received until the next business day so may be considered late notice.

Late notice, not arriving for your appointment, or arriving too late to be treated can result in a $75 charge for the time put aside by the clinician. We realize that some situations affecting your schedule are unexpected and unavoidable, so please contact us as soon as possible and we will work with you.

If there are repeated broken appointments or late cancellations, our office may decide not to schedule any future appointments with your household.

We are an amalgam-free practice! Dr. Kroepel only uses tooth-colored composite fillings and does not use silver amalgam restoration material. In some cases, dental insurance will not cover the fee difference between amalgam and composite filling, so you are responsible for the difference in cost. Please ask if you have any questions or concerns about the difference in restoration material and the fees.

I have read, understand and agree with the office policies. These policies may change without notice.

Signature of patient or guardian:_____

Printed Name:_____ Date: _____

Robert T. Kroepel, Jr., D.M.D., P.C.
GENERAL DENTISTRY AND SLEEP CARE

243 Broad Street Milford, CT 06460 P (203) 877-1233 F 203-876-1166

Email: ContactUs@MilfordCTDental.com MilfordCTDental.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PRIVATE HEALTH INFORMATION

Release for your dental or medical provider

To Whom It May Concern, please release my dental or medical records *(circle)* to / from Dr. Robert T. Kroepel, Jr.

And (*circle)* to/from (provider) _____.

Provider/Practice Address:

Phone/Fax/Email:

Patient Name:

Patient Date of Birth:

Telephone:

Parent or Guardian (if needed):

Provider/Practice Address:

Phone/Fax/Email:

Patient (or Guardian) Signature: _____Date:

Office Use:

Please send ___Recent dental images ___Previous sleep study ___Other

PERMISSION TO DISCLOSE OR DISCUSS MY TREATMENT AND RECORDS WITH DESIGNATED FAMILY OR CAREGIVERS

I, _____, direct Dr. Robert T. Kroepel Jr. and staff to disclose and release my protected health information All Information ___ Financial Only ____ Health Information Only to the following person:

Name:

Relationship:

Contact information:

This authorization will be effective:

__ Indefinitely OR __ until this date: _____, unless I revoke it.

Patient (or Guardian) Signature: _____ Date:

You may revoke this authorization at any time by notifying your health care providers in writing.

Rev. 020718ls