The Kodish Family Group

Dentistry For A Lifetime of Beautiful Smiles

REGISTRATION & HEALTH HISTORY

Patient_____ Date_____ Chart#_____

Social Security #_____ E-mail Address_____

Birthdate_____ Age_____ Occupation_____

Address_____ Employer (or School)_____

City/State/Zip_____ Address_____

Phone_____ Dental Ins.Co._____

HOME WORK/CELL

Has any other member of your family been treated in our office? ☐ YES ☐ NO

Group#_____

Who may we thank for referring you? _____

Person responsible for this account: ☐ PATIENT ☐ SPOUSE ☐ PARENT of child ☐ OTHER

SPOUSE		PARENT of child
_____	Name	_____
_____	Birthdate/S.S.#	_____
_____	Employer	_____
_____	Address	_____
_____	Dental Ins.Co.	_____
_____	Group#	_____
_____	Work Phone	_____

Consent for Treatment

I hereby authorize the doctor or staff to take x-rays, study models, photographs and/or any other diagnostic aids deemed necessary by the doctor to make a thorough diagnosis of me or my dependent's dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment agreed upon by me and to give such assistance as required to provide proper care. I agree to the use of anesthetics or other medications as necessary. I fully understand that using anesthetic agents carries certain risks. I understand that I may ask for a full explanation of any possible complications.

I understand that I am responsible for payment of all services rendered on behalf of me or my dependents, regardless of insurance benefits. I understand that payment is due at the time service is rendered unless other arrangements have been made. I am aware that this office charges for broken appointments without adequate notice. I understand that a 15% (18% APR) charge will be assessed to my account for any balance over 45 days old. Accounts more than 90 days past due may be turned over to a collection agency in which case a collection fee will be assessed. I certify that the information I have given on this form is correct to the best of my knowledge.

SIGNATURE OF PATIENT (OR GUARDIAN OF MINOR)_____**Date**_____

Photography Release

I authorize the taking of photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication,newspapers, magazines, phone books, television) and professional publications (dental magazines and journals.) I further understand that if the photographs, slides, and/or videos are used in a publication or as part of a demonstration, my name or other identifying information will be kept confidential and I will not receive compensation, financial or otherwise, for the use of these photographs.

SIGNATURE OF PATIENT (OR GUARDIAN OF MINOR_____

Insurance Release: I hereby authorize release of any information necessary to process and/or pay my insurance claims.

SIGNATURE OF PATIENT (OR GUARDIAN OF MINOR)_____**Date**_____

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices of this office. (You have the right to refuse to sign this acknowledgment.)

NAME (Please Print)_____

SIGNATURE OF PATIENT (OR GUARDIAN OF MINOR)_____ **DATE**_____

~Office Use Only~

We were unable to obtain acknowledgment of receipt of our Privacy Practices Notification from the person noted above for the following reason:

[ ] An emergency prevented us from obtaining acknowledgment

[ ] A communication barrier prevented us from obtaining acknowledgment

[ ] The individual was unwilling to sign [ ] Other: _____