VIVIAN R. KUNSTMANN

Name: _____

Preferred Name: _____

Birthdate: _____ SS #: _____

Home Address: _____

_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Ph: _____ Pager/Cell: _____

Work Ph: _____ Ext #: _____

E-mail Address: _____

What is the best method to reach you? _____

Employer: _____ Occupation: _____

Present Dentist: _____ How Long? _____

Last Visit Date: _____

Has any member of your family ever been treated in our office?
☐ Yes ☐ No

Whom may we thank for referring you? _____

Responsible Party Information or Policy Holder Information

Name: _____

Relationship to Patient: _____

Birthdate: _____ SS #: _____ ID #: _____

Home Address: _____

_____

Home Ph: _____ Pager/Cell: _____

Work Ph: _____ Ext #: _____

Employer: _____

Dental Ins. Co.: _____ Group #: _____

Insurance Co. Phone: _____

Emergency Contact Information

Name: _____

Relationship to Patient: _____

Home Ph: _____ Pager/Cell: _____

Work Ph: _____ Ext #: _____

Have you ever had any of the following: ***(please check)***

☐ Anemia / Hemophilia / Abnormal Bleeding
☐ Arthritis
☐ Artificial Bones / Joints
☐ Asthma
☐ Blood Transfusion
☐ Bronchitis
☐ Bruise easily
☐ Cancer / Radiation / Chemotherapy
☐ Congenital Heart Disease
☐ Diabetes
☐ Difficulty Breathing
☐ Drug / Alcohol Abuse
☐ Emphysema
☐ Epilepsy / Seizures / Fainting Spells
☐ Fever Blisters / Shingles / Cold Sores
☐ Glaucoma
☐ Heart Surgery other than Bypass
☐ Hepatitis A,B,C, or Delta / Liver Dx
☐ High / Low Blood Pressure
☐ HIV / AIDS
☐ Kidney Problems
☐ Lupus
☐ Lung Surgery
☐ Neuromuscular Disorder
☐ Organ Transplant
☐ Osteoporosis
☐ Previous Endocarditis
☐ Psychiatric Problems
☐ Severe or Frequent Headaches
☐ Sinus Problems / Allergies
☐ Stroke / Heart Attack
☐ Thyroid Problems
☐ Tuberculosis (TB)
☐ Ulcers / Colitis
☐ Venereal Disease

Are there any other medical concerns that we should know about? _____

What is the primary reason for this dental appointment? _____

Are you currently taking any medication? ☐ Yes ☐ No If so, which: _____

Are you taking sexual enhancement drugs? ☐ Yes ☐ No If so, which: _____

Are you currently under a physician's care? ☐ Yes ☐ No Who? _____

Are you pregnant? ☐ Yes ☐ No Are you taking contraceptives? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

Check choices that apply to you: ☐ Cavities ☐ Sensitive teeth ☐ Bad breath or taste ☐ Bleeding gums ☐ Grinding Teeth ☐ TMJ Pain

Have you ever thought about changing the color or shape of your teeth? ☐ Yes ☐ No

What is most important to you about your dental health? ☐ Health ☐ Appearance ☐ Longevity ☐ Function

What is most important to you about your relationship with a dentist? ☐ Competence ☐ Bedside Manner ☐ Knowledge ☐ Friendliness

☐ Sense of Humor Other: _____

What did you like / dislike about your past dental appointment? ☐ Treatment uncomfortable ☐ Staff ☐ Fee concerns ☐ Cleanliness

Other: _____

Does dental treatment make you nervous? ☐ Yes ☐ No Would you like to be asleep during dental treatment? ☐ Yes ☐ No

I authorize discussion of my dental treatment and finances with _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

A Dental Insurance Plan is a contract between you and your employer, or plan sponsor. It is designed to share in your dental care costs. It will not cover the total cost of your bill. We are not a participating provider to all dental plans. If insurance is to cover a portion of my treatment, I understand that I am responsible for whatever the insurance does not cover.

Signature ***(Parent of Guardian if patient is a minor)*** _____ Date: _____

VIVIAN KUNSTMANN, D.D.S.

9291 GLADES ROAD • SUITE 304 • BOCA RATON, FL 33434

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have reviewed/received a copy of
Patient Name

VIVIAN KUNSTMANN, D.D.S. 's Notice of Privacy Practices.
Practice Name

_____ _____
Signature of Patient / Guardian Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: