



Welcome to our family of fine patients and thank you for selecting us as your personal dental care team. We will always strive to make your relationship with us as pleasant and rewarding as possible.

Your visit with us will consist of meeting our team, taking a tour of our office, and a comprehensive exam with Dr. Koch.

Responsible, professional dental care relies on providing a firm foundation on which we can base recommendations for your dental health. Therefore, your next visit with us may consist of a thorough examination and any necessary x-rays that will aid us in giving you the finest dental care possible. Feel assured that we will only recommend the minimal x-rays needed and that we will show you how to control your dental destiny. Because our office employs the use of digital (computerized) x-rays exclusively, the amount of radiation is reduced as much as 90% compared to traditional x-ray systems.

Enclosed you will find a health record form that we would like you to complete and bring to our office on the day of your visit. Your overall health can significantly affect your oral health and a thorough health record allows us to make a more thorough diagnosis. Our goal is for you to be happy with our office and completely satisfied in feeling that we are unconditionally committed to making you feel special. A misunderstanding can be an obstacle to forming this relationship and we ask that if at any time you have a question or are unhappy about any treatment, fee, or service, please discuss it with us promptly and openly.

A long term, mutually satisfying relationship, which gives you the ability to maintain optimum dental health, is what we want for you, your family, and for our own satisfaction. Thank you again for selecting us and we are looking forward to seeing you.

Sincerely,

J. Paul Koch, D.M.D.
Enclosures



WELCOME

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

About You

Today's date _____

Mr./Mrs./Ms./Miss Name: _____

I like to be called: _____

Home address: _____ City: _____

Zip: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Student: _____ School Attending: _____

Date of birth: _____ Who may we thank for referring you? (social media, online search, current/previous patient name etc.) _____

Marital status: Single Married Divorced Widowed

Spouse's name: _____

Do you have dental insurance? _____ Parent/guardian name if patient is a minor: _____

Employer: _____ Date of Birth: _____

Special interests or hobbies: _____

Telephone Information

Home phone: _____

Work phone: _____

Cell phone: _____

E-mail address _____

When is the best time to call you? _____ and Where? _____

In case of emergency, is there someone we can call?

Name: _____ Phone Number: _____

Medical History

Name of personal physician: _____ Phone number: _____

Last visit with physician: _____ Current Health: Excellent Good
Fair Poor

Do you smoke or use chewing tobacco? Yes No If Yes, How Much Per Day? _____

Do you consume alcohol? Yes No If yes, in what quantities? _____

Are you currently taking prescription medications? Yes No, if yes, please list below

Name of medication	Purpose
_____	_____
_____	_____
_____	_____

For Women: Are you pregnant? Yes No, if Yes, how many months? _____

Do you plan on becoming pregnant in the near future and when? _____

Have you had any serious medical problems within the past 5 years? Yes No, if yes, please explain: _____

Please **circle** if you have, or have ever had, or been treated for any of the following diseases or medical problems?

- | | | |
|------------------------|----------------------|-----------------------|
| Abnormal bleeding | Emphysema | Mitral Valve Prolapse |
| AIDS/HIV | Epilepsy | Nervous Disorder |
| Allergies (Seasonal) | Excessive Bleeding | Pacemaker |
| Anemia | Facial/Head Injuries | Prosthetic Valves |
| Arthritis | Fainting | Psychiatric Problems |
| Artificial Heart Valve | Glaucoma | Radiation |
| Asthma | Headaches | Respiratory Problems |
| Blood Disorder | Heart Conditions | Rheumatic Fever |
| Cancer _____ | Heart murmur | Rheumatism |
| Chemotherapy | Hepatitis/Jaundice | Scarlet Fever |
| Depression | High Blood pressure | Seizures |
| Diabetes | Jaundice | Stomach Problems |
| Digestive Problems | Joint Implants | Stroke |
| Dizziness | Kidney problems | Thyroid Disease |
| Drug/Alcohol abuse | Liver Disease | Tuberculosis |
| Eating Disorders | Low Blood Pressure | Ulcers |
| | | Venereal Disease |

Have you been treated for any other illnesses not listed above? Yes No, if yes, please explain: _____

Do you need to be pre-medicated before dental treatment? Yes No Don't know

Are you allergic to any of the following? Y N Penicillin Y N Aspirin Y N E-mycin
 Y N Codeine Y N Dental Anesthetic Y N Latex

Are you allergic to any other medications? Yes No, if yes, please explain: _____

Have you recently or are you currently taking Fosamax, Boniva, Actonel, Pamidronate IV or Zolendronate IV? Yes No

Dental History

Are you currently in pain or discomfort with your teeth or gums? Yes No, if yes please explain: _____

Previous dentist's name? _____

Reason for leaving? _____

The date of your last dental visit: _____ Date of last x-rays _____

Date of last oral cancer screening: _____ Date of last gum charting: _____

Do you have or have you had any of the following: Braces? _____ Gum Treatments? _____

How often do you brush your teeth? _____ Floss your teeth? _____

Do your gums bleed when you brush? Yes No Floss? Yes No

Do you have swollen or irritated gums? Yes No

Do you or have you ever experienced bad breath? Yes No

Have you ever experienced pain in your jaw joint Yes No

Do you grind or clench your teeth? Yes No

Do you notice your jaw clicking or popping? Yes No

Have you ever been treated for TMJ symptoms? Yes No, if yes please explain:

Do you notice discomfort in face, head, neck or jaw? Yes No

Are your teeth sensitive to sweets, hot or cold? Yes No Where? _____

Are any of your teeth loose? Yes No Are any of your teeth tipped or shifting? Yes No

Have you had any problems with previous dental treatment? Yes No If so, please explain _____

Do you need nitrous, oral /IV sedation for dental visits? Yes No

"If I could change my smile, I would": (circle all that apply)

- Safely make my teeth whiter
- Make my teeth straighter
- Close spaces
- Replace metal fillings with tooth colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns/veneers that don't match
- Have a smile makeover
- Make sure my mouth is healthy

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

To avoid any misunderstandings regarding your dental insurance, we wish our patients to know that **all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees.** We do not render services on the basis that the insurance companies will pay our fees unless a pre-determination of benefits has been established. We will assist you in filing all insurance forms. **Payment is due when services are rendered unless other arrangements have been made.**

I hereby authorize Dr. Koch to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Koch to make a thorough diagnosis of my dental needs. I also authorize Dr. Koch to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon. I give Dr. Koch or his team permission to use any photos he may take to be used for lecturing or educational purposes.

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. I understand that responsibility for payment for dental services provided in this office for my dependents or me is mine, due and payable at the time services are rendered.

Signature of patient or responsible party _____

Date _____

KOCH AESTHETIC DENTISTRY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
-
-
-

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).



GUEST FINANCIAL ALLIANCE

Welcome to our office. We are honored that you have chosen us as your dental healthcare provider. We are committed to providing you with the best possible care! If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment alliance. We will always clarify financial arrangements prior to treatment.

1. PAYMENT IS DUE AT TIME SERVICES ARE RENEDED unless other payment arrangements have been approved, in advance, by our staff. We accept payment for services in cash, check, American Express, Mastercard or Visa. _____ (please initial).
2. If you have dental insurance we will be happy to file and have your insurance company reimburse you.
3. For extensive treatment we offer an accounting courtesy for treatment over \$5000 and is paid in full prior to the service.
4. As a courtesy to our patients, we have extended financing available through CareCredit and/or Healthcare Finance. These resources are available to support you in having optimal treatment when you need it. Please check if you are interested in extended financing. Yes____ No____
5. Fees quoted are accepted for 90 days. In the event that clinical conditions warrant a different treatment, you will be notified of changes in fees prior to proceeding with the procedure.
6. Balances older than 60 days will be subject to interest charges of 1.5% per month, or 18% annually.
7. A \$32.00 NSF fee will be charged for all returned checks.
8. In the event that payment is not made for services after a reasonable period of time, our attorney will be advised and formal action to collect will be initiated. You will be responsible for any attorney's fees and/or collection charges incurred.
9. Broken appointments and appointments canceled with less than 24 hours advance notice will be subject to a broken appointment or last minute cancellation fee.

Insurance

The process of utilization and quality of insurance has changed much over the years. We will do our best to help you understand and utilize your benefits. The amount of coverage your insurance provides is strictly a function of the policy selected by you and your employer.

Note: Your insurance is a contract between you, your employer and the insurance carrier. We are not a party to that contract. If you have a problem with your insurance coverage, we ask that you speak directly to your insurance company. Your charges in our office are your responsibility from the date the services are rendered. We do not base your diagnosed treatment on your insurance coverage. We base it on your need and desires. We take pride in the quality care we offer our patients and make every effort to have your dental visits with us be as comfortable as possible.

Thank you for reviewing our financial policy. We make every effort to explain your costs to you and to avoid misunderstandings so that we can focus on your dental health. If you have any questions please ask. We are here to serve you.
I have read, understand and agree to abide by this policy. I have been given the opportunity to receive a copy of this document.

Signature _____ Date _____

Witness _____ Date _____



LEVELS OF CARE

We understand that choosing a new dentist and dental health team can be a challenge, leaving you feeling somewhat uncertain. Let us welcome you and share some insights about what we do for our patients. The philosophy guiding our practice is as follows:

"Our purpose is to help people achieve the highest level of well-being appropriate for them and, in so doing, to enhance the quality of their lives."

In other words, we help you be or become as healthy as you choose. This is a major departure from the way we were trained. Instead of telling you how healthy you ought to be, we will try to help you understand your choices about dental health and then let you make a free and informed decision. Your first choice in this regard is how you would like to begin with us. There are five levels on which people may choose to be seen in our practice. Please **initial** the level of care you feel most appropriate for you at this time.

_____ **Level 1 URGENT CARE:** People in crisis or with an emergency problem such as pain, swelling, or bleeding that need our immediate help are at this level. We see urgencies immediately, whenever possible.

_____ **Level 2 REMEDIAL CARE:** People who choose this level of care desire treatment only when something breaks or becomes uncomfortable. Generally people at this level expect a limited type of examination, focusing on obvious problems. They usually want to correct immediate problems with as little effort and cost as possible.

_____ **Level 3 SELF-CARE:** Patients who choose this level of care want a thorough examination and take an active part in the treatment and prevention of present and future disease problems. However, they usually choose repair solutions that are short range in nature.

_____ **Level 4 COMPLETE DENTISTRY:** Patients at this level are similar to people described in level 3. They choose to have a thorough examination. However, they decide on a MASTER PLAN to formulate a long-term treatment plan for health and repair. These patients are very concerned about treating the causes of dental disease, not simply the effects. These patients want all dental treatment provided to be completed in the most lasting fashion possible.

_____ **Level 5 LOOK YOUR BEST:** People in this group are in Level 4 as far as dental health is concerned, but also want to look their best at all times. They know that their smile is the first thing others notice about them and want to put their best foot forward.

We hope these levels of care make sense to you. It is not uncommon for people to begin at one level and progress to another over time. We are here to help you discover and decide at what level you are most comfortable. Thank you for the opportunity to serve you and provide you with the best dentistry appropriate for you.

Sign _____ Date _____