KACHER
DENTISTRY

Registration – Adults

Name:		DOB:	SS#:
Address:			
City:	ST:	ZIP:	Driver's Lic. #:
Home #:	Work #:		Cell #:
E-mail:			Single Married Other
Emergency Contact Name:		Phone #:	Relation:

DENTAL INSURANCE – PRIMARY

Policy Holder Name:		DOB:
Employer:		SS#:
Dental Ins. Co. Name:		Ins.Phone #:
Claim Mailing Address:		
Group #:	Member ID #:	Policy ID#:

DENTAL INSURANCE – SECONDARY

Policy Holder Name:		DOB:
Employer:		SS#:
Dental Ins. Co. Name:		Ins.Phone #:
Claim Mailing Address:		
Group #:	Member ID #:	Policy ID#:

Please be advised that our office is OUT-OF-NETWORK with all insurance companies. Dr. Kacher and Dr. Abay do not participate in any PPO, DMO or HMO plans. Therefore, any benefits used in our office will be considered out-of-network with your insurance company.

As a courtesy to you, our office will bill your insurance carrier. We will collect an estimated co-payment from you on the day of your treatment. In any event that your insurance company does not pay for the balance of procedures performed, you are ultimately responsible for your account balance within 60 days from any treatment.

FINANCIAL RESPONSIBILITY IF OTHER THAN SELF

Name:
Address:
Phone:

*Who may we thank for inviting you to our office?*_____

_____ _____

PATIENT SIGNATURE **DATE**

KACHER
DENTISTRY

Confidential Health History

Patient Name:		Birthdate:
Physician Name:		Physician Phone Number:
Preferred Pharmacy:	Location (Cross streets):	Phone:

Please circle yes or no

Are you currently under the care of your physician?	YES	NO		
If yes, why?				
Date of last visit with physician:	May we contact them if medical info needed?		YES	NO
Date of last dental visit:				

Are you currently taking medications of any kind?	YES	NO
Prescription:		
Non-prescription:		

Have you been hospitalized in the past 3 years?	YES	NO
If yes, please explain:		

Are you allergic to any medications?	YES	NO
If yes, please list name and reaction:		
Are you allergic to **LATEX**?	YES	NO

Have you previously had or currently have any of the following?					
MITRAL VALVE PROLAPSE	YES	NO	JOINT REPLACEMENT	YES	NO
HEART VALVE REPLACMENT	YES	NO	RHEUMATIC FEVER	YES	NO
Do you need antibiotic pre-medication before dental treatment?	YES	NO			

Have you taken any of these medications in the last 6 months?			
Cortisone or other steroids	YES	NO	Drug Name:
Anticoagulants or blood thinners	YES	NO	Drug Name:
Tranquilizers or antidepressants	YES	NO	Drug Name:
Nitroglycerine or thyroid extract	YES	NO	Drug Name:

Have you previously had or currently have any of the following conditions?		
Bleeding problems	X-ray therapy	Lung condition
Heart condition	Chemotherapy	Joint Replacement
Liver condition	Blood disorder	High blood pressure
Hepatitis	H.I.V.	A.I.D.S.
Cancer	Diabetes	Blood transfusion

Tobacco use?	YES	NO	*Smoke:*	Pipe	Cigar	Cigarettes	Frequency:	
			Smokeless:	Type:			Frequency:	
Alcohol use?	YES	NO		*Amount:*	Minimal	Moderate	Heavy	
Women: Are you pregnant?	YES	NO				Are you nursing?	YES	NO

PATIENT OR PARENT SIGNATURE_____ **DATE**_____

KACHER
DENTISTRY

General Informed Consent to Perform Dentistry

1. I hereby authorize and direct the dentist(s) of Kacher Dentistry and/or dental auxiliaries of their choice, to perform the following dental treatment or oral surgery procedures(s) including the use of any necessary or advisable local anesthesia, radiographs (X-rays), or diagnostic aids:
    A. Preventive hygiene treatment (prophylaxis) and application of topical fluoride.
    B. Application of sealants to the grooves of the teeth.
    C. Treatment of diseased or injured teeth with dental restorations (fillings & crowns).
    D. Replacement of missing teeth with dental prostheses (fixed bridges, implants, removable partials or dentures).
    E. Removal (extraction) of one or more teeth.
    F. Use of sedative drugs to control apprehension.

2. I understand that there are risks involved in any treatment and hereby acknowledge that these risks will be explained to me and that I will have an opportunity to ask questions regarding the treatment and the risks and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece can leave a small indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary to oral health and well being in the professional judgment of the dentist(s).

5. There are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctor(s) to use photographs, radiographs and other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

7. I will be advised that the success of the dental treatment to be provided will require that the patient or/and the legal guardian(s) follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent and all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

PATIENT NAME_____ **PARENT OR GUARDIAN NAME**_____

SIGNATURE OF PATIENT/PARENT/GUARDIAN_____ **RELATIONSHIP TO PATIENT**_____

WITNESSED BY_____ **DATE**_____ **TIME**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Kacher Dentistry

✧You May Refuse to Sign This Acknowledgment✧

I, _____, have reviewed/received a copy of this office's Notice of Privacy Practices.
(*print PATIENT name)*

_____

Please Print PATIENT Name

_____

Signature of Patient or Guardian ***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
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____