GEORGE KOURAKIN • DMD PA

Thank you for choosing "My Dentist", Dr. Kourakin, for your dental needs. We are very pleased that you chose to schedule with our practice. Dr. Kourakin and the staff are looking forward to meeting you and helping you with your dental and/or facial cosmetic needs.

Enclosed are your patient registration paperwork, your appointment card and business cards for you to keep or share. Dr. Kourakin would also like to extend a special courtesy to you as our patient and give you his personal cell phone number in the event that you have an emergency or questions about upcoming procedures. His cell phone number is (609) 442-4404. Please respect his privacy and do not make this number public.

Our staff is available to help you Monday through Friday from 8:00 until 5:00pm. Please feel free to contact us at any time if you have questions, as we want our patients to be fully educated and involved in their treatment.

Please go to our website at www.allmydentists.com for a more informative look at our outstanding office.

The Office of George Kourakin, DMD

George Kourakin, DMD PA, Arthur Alperstein, DMD, Julie, RDH, Becky, RDH, Dana, RDH, Danielle, RDH, Jennifer, RDH, Brenda, Shelly and Katrina.

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City:
State:
Zip:

Occupation:
Height:
Weight:
Date of Birth:
Sex: M F

SS# or Patient ID:
Emergency Contact:
Relationship:
Home Phone: *Include area code* ( )
Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

	Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name:
Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

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Form S500

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: ________ If yes, have you had any complications? ________			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: ________			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? ________			
If yes, how much do you typically drink i n a week? ________			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: ________			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics ________	☐	☐	☐
Aspirin ________	☐	☐	☐
Penicillin or other antibiotics ________	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ________	☐	☐	☐
Sulfa drugs ________	☐	☐	☐
Codeine or other narcotics ________	☐	☐	☐
Metals ________	☐	☐	☐
Latex (rubber) ________	☐	☐	☐
Iodine ________	☐	☐	☐
Hay fever/seasonal ________	☐	☐	☐
Animals ________	☐	☐	☐
Food ________	☐	☐	☐
Other ________	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: ________			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: ________			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: ________			
Recurrent Infections	☐	☐	☐
Type of infection: ________			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

A Reason to Smile — MyDentist — GEORGE KOURAKIN · DMD PA — Cosmetic & Family Dentistry

856-825-0618

www.allmydentists.com

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

I have completed this form in full and completely, and I certify that I am the patient or duly authorized to furnish the information requested. ***I understand that although***

Email Address:	Today's Date:

As required by law, our office adheres to written policies & procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only & will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire & there may be additional questions concerning your health. This information is vital and allows us to provide appropriate care for you.

Name: Last:	First:	Middle:
Phone: Home:	Work:	Cell:
Street Address:		DOB:
City:	State:	Zip:
SS#:	Driver's License #:	
Has any member of your family been treated in our office? ____YES ____NO		
How did you hear of our practice?		
Place of employment (or school)		
Address:		
City:	State:	Zip:
Work Phone:		Extension:
Name of Insured:		Relationship to Patient:
DOB:	SS#:	Date of Hire:
Address:		
Insurance Co.:	Group #:	Member ID:
Insurance Co. Address:		
Insurance Co. Telephone:		Do you have additional insurance? ___Yes ___NO
Name of Insured:		Relationship to Patient:
DOB:	SS#:	Date of Hire:
Address:		
Insurance Co.:	Group #:	Member ID:
Insurance Co. Address:		Insurance Co. Telephone:
Person responsible for this account:		Address:
Telephone:		Relationship to Patient:

I have some type of insurance coverage, I am responsible for my portion of the dental visit at time of service and that I am solely responsible for services that my insurance does not cover. I authorize and consent to the release of all medical/dental information necessary to process my claims and I authorize the release of the same information, when necessary, to other providers rendering medical/dental care. I assign all dental benefits, which I am entitled, to George Kourakin, D.M.D., P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Finance charges: If I don't pay the entire new balance **within 28 days** of the monthly billing date, a Finance Charge will be added to the account for the current monthly billing period. The finance charge will be a periodic rate of 1.5% per month (or minimum charge of $2.00 for balance under $134.00) which is an annual percentage rate of 18% applied to the last month's balance. In the event of a default payment, I promise to pay any legal interest on the balance due, together with any collections costs and reasonable attorney fees incurred to affect collection on this account.

Print Name:	Sign:	Date:

AS PER OUR OFFICE POLICY, *PAYMENT IS DUE AT TIME OF SERVICE.*

Privacy Policy acknowledgement:

I acknowledge that I have been given an opportunity to read this office's Notice of Privacy Practices.

Appointment Policy:

Please be advised that the appointments we schedule for you are reserved specifically for you. We require 48 hours notice when canceling or rescheduling your appointment. A fee **WILL** be charged without sufficient notice.

____

Please Print Name

____

Signature

Financial Policy:

Full payment is due at time of service. All co-payments, deductibles and payment for non-covered services are due at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

____

Please Print Name

____

Signature   Date

Technology is the wave of the future! Therefore, we are asking that you provide us with your cell phone number and email address so that we may remind you of upcoming appointments. This information will only be used for the purpose of contacting you with your appointment reminders.

____   ____

Cell Phone Number   E-mail address