Janet Stukalin, D.D.S.
5925 Forest Lane #318 • Dallas, Texas 75230 • 972-490-4881

Personal Information

Patient's full name _____ Date _____

Address _____ City _____ State _____ Zip _____

Email address _____ (this will not be used for marketing)

Phone Home _____ Work _____ Cell _____

Social Security Number _____

Date of Birth _____ Age _____

Marital Status: ☐ Single ☐ Married ☐ Minor

Employers Name & Address _____

Spouse's Name & Occupation _____

Spouse's Employer & Address _____

Person Responsible for Account _____ Relationship _____

Whom may we thank for referring you? _____

Contact Preferences

	Email	Text Msg	Phone
Reminder For Upcoming Appointments (1 week notice in advance)			
Reminder 24 Hours Before Your Appointment (To help insure you will not forget an appointment and incur a fee.)			
Notification that a year or more has passed since your last appointment.			

Please list email, phone, or cell phone number you prefer if it differs from the ones listed above _____

_____ _____

Patient's or Guardian's Signature Doctor's Signature

Health History

Patient's Name _____

Physician's Name _____
Address _____ Phone _____

Are you currently under a physician's care for any conditions? ☐ Yes ☐ No

Have you been hospitalized or had a major illness within the last 5 years? ☐ Yes ☐ No
Explain _____

Have you ever had an adverse reaction to a dental anesthetic? ☐ Yes ☐ No

Are you allergic to latex or metal? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No

_____

_____

Do you have any type of Artificial Joint, Heart Valve, or Pacemaker? ☐ Yes ☐ No
List dates of surgeries _____

_____

Have you been told you need to be pre-medicated before a dental appointment? ☐ Yes ☐ No

Do you take a blood thinner? ☐ Yes ☐ No

Do you know what your blood pressure normally runs? List _____/_____ ☐ Yes ☐ No

Do you have mitral valve prolapse with regurgitation? ☐ Yes ☐ No

Do you use **ANY** tobacco products? ☐ Yes ☐ No
Type _____ Amount per day _____

Have you noticed any acid reflux? Frequency _____ ☐ Yes ☐ No

Have you taken or do you take I.V. or oral bisphosphonates? (i.e. Actonel, Fosamax)? ☐ Yes ☐ No

List all medications you take and for what reason

Medications	Reason

List vitamins you take

Estimate the number of servings you consume daily of the following:
Coffee _____ Tea _____ Soft Drinks _____ Gatorade _____Acidic foods (lemons, tomatoes, salsa) _____

Medical Condition

Heart Failure	☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No
Heart Disease/Heart Attack	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Hepatitis A (infectious)	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Hepatitis B (serum)	☐ Yes	☐ No
Arteriosclerosis	☐ Yes	☐ No	Hepatitis C	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	AIDS	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Rheumatism	☐ Yes	☐ No	Cold Sore/Fever Blisters	☐ Yes	☐ No
Cortisone Medication	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No	Sickle Cell Anemia	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Nervousness/Anxiety	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Asthma	☐ Yes	☐ No			
Hay Fever	☐ Yes	☐ No			

Females Only

Are you pregnant?	☐ Yes	☐ No
Using Birth Control?	☐ Yes	☐ No
Taking Hormones?	☐ Yes	☐ No
Nursing?	☐ Yes	☐ No

Dental Health

1. When was your last dental visit? _____ Cleaning? _____
2. What dental concerns do you wish to discuss at today's visit? _____
   _____
3. Have you had braces? ☐ Yes ☐ No
4. Are any teeth rotated now that you are aware of? ☐ Yes ☐ No
5. Have you had an unfavorable dental visit? ☐ Yes ☐ No
   If so, explain: _____
6. Have you have any gum trouble or treatment? ☐ Yes ☐ No
   If yes, what treatment: _____
7. Do your gum bleed? ☐ Yes ☐ No
8. Do you have any dental pain or tenderness? ☐ Yes ☐ No
9. Are you sensitive to hot, cold, or sweets? ☐ Yes ☐ No
10. Do you have mild to moderate tooth pain that comes and goes? ☐ Yes ☐ No
    If yes, how often: _____
11. Does food catch between your teeth? ☐ Yes ☐ No
12. Do you have dry mouth? ☐ Yes ☐ No
13. Do you feel like you clench or grind your teeth? ☐ Yes ☐ No
14. Do you have pain in your ear or neck area? ☐ Yes ☐ No
    If so, explain: _____
15. Are any of your teeth yellow or discolored? ☐ Yes ☐ No
16. Would you like them whiter? ☐ Yes ☐ No
17. Do you have any missing teeth? ☐ Yes ☐ No
18. Are the edges of any teeth worn down, chipped, or uneven? ☐ Yes ☐ No
19. Do you have any prior dental work that appears unnatural? ☐ Yes ☐ No
20. Do you have any crowns or bridges that appear dark at the edge? ☐ Yes ☐ No
21. Do you have any gray, black, or silver fillings that you do not like the appearance of? ☐ Yes ☐ No
22. Does the appearance of your smile inhibit you from laughing or smiling? ☐ Yes ☐ No
23. When being photographed, do you smile with your lips closed instead of a full smile? ☐ Yes ☐ No
24. Are you self-conscious about your teeth or smile? ☐ Yes ☐ No
25. Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No
    If not, what would you like to change? _____
26. Do you have pain in your jaw joints (TMJ)? ☐ Yes ☐ No

_____ _____ _____

Patient's or Guardian's Signature Doctor's Signature Date

Smile Analysis

Your smile affects your self-image and can greatly influence the quality of your interactions with other. Many people hold back from laughing or smiling because they are uncomfortable with their smile. The following questions are designed to honestly appraise your smile. Go to a mirror, smile as wide as you can, and ask yourself the following questions:

	Yes	*No*	*Does this bother you*
Are any of your teeth yellow, stained or somewhat discolored?	0	0	0
Would you like your teeth to be whiter?	0	0	0
Do you have any gaps or spaces between your teeth?	0	0	0
Are any of your teeth turned, crooked or uneven?	0	0	0
Are you missing any of your teeth?	0	0	0
Are the edges of any teeth worn down, chipped or uneven?	0	0	0
Do you have any prior dental work that appears unnatural?	0	0	0
Do you have any crowns or bridges that appear dark at the edge of your gums?	0	0	0
Do you have any gray, black or silver fillings in your teeth?	0	0	0
Are your gums red, sore, puffy, bleeding or receded?	0	0	0
Does the appearance of your smile inhibit you from laughing or smiling?	0	0	0
Are you self-conscious about your teeth or smile?	0	0	0
Would you like to change anything about the appearance of your teeth or smile?	0	0	0
When being photographed, do you smile with your lips closed instead of flashing a full smile?	0	0	0

*If you answered **YES** to **ANY** of the questions above, there are often several alternatives to improve your teeth and smile.*

Please fill out this form ONLY if you want to be contacted by Email/Text.

You have requested that our practice communicate with you electronically. By utilizing our practice's electronic services, you agree that (*Drs. Stukalin, P.A.*) may send to you any of the following that you identify as communication that can be sent through the Internet to an email address you designate.

Consent and Acknowledgement

I _____, in the presence of my dentist or the dental practice's privacy official, agree that the practice may electronically communicate with me at the following email address.

Patient's Date of Birth:_____

Your email address:_____

Additional persons authorized to receive information and their email address:

_____

I acknowledge that the practice may send the following to **my email, my spouse or an assistant**. Check each that apply, and then provide your initials at the end of each item selected.

Information about my invoice or accounts payable. _____(initials)

Information about a specific dental visit. _____(initials)
Specify_____

Information about any dental visit. _____ (initials)

Acknowledgement

You must acknowledge each of the following before we can send communications electronically.

_____I am responsible for providing the dental practice any updates to my email address.

_____I can withdraw my consent to electronic communications by calling **972-490-4881**

Patient's Signature_____Date_____

Dr. Janet E Stukalin, D.D.S. Financial Policy and Agreement

Thank you for choosing D. Janet Stukalin as your dental health care provider. The following is an explanation of our Financial Policy Agreement, which should be read and signed prior to your dental treatment.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than forty-eight (48) business hours' notice are considered broken. Broken appointments prevent other patients from receiving the dental care they deserve. We take them seriously, so please be considerate and inform us in advance if you need to change your appointment. We reserve the right to terminate professional treatment of any patient when scheduled appointments are repeatedly not kept, or ask for pre-payment of future appointments.

PATIENTS WITH DENTAL INSURANCE: Our office will be happy to fill out necessary paperwork to help get your reimbursement; however your dental plan is a contract between you and your plan provider. We are not a party to that contract. As a courtesy, we will submit claims to your dental plan. In order to facilitate claims processing, you must provide all dental plan information and any changes to our office. Your bill is your responsibility whether your dental plan pays or not. At times, you may need to contact your dental plan regarding slow or non-payment of your claim(s).

A pre-treatment estimate may be done to learn what your insurance company may pay. Unfortunately, your insurance carrier will NOT guarantee any information given to us; therefore, we cannot guarantee what percentage of your treatment they will cover. We do not base our diagnosis on what your insurance will, or will not cover. Diagnosis of treatment is based on your dental health and what the teeth, bone, and/or gums are in need of, in a conservative approach. The patient is ultimately responsible for all charges incurred with our office should your insurance carrier not pay for any reason.
Fees given on any treatment proposal are valid for 6 months and subject to change after that period.

Patient Signature _____

Date _____

Drs. Stukalin, P.A.

5925 Forest Ln Ste 318

Dallas, TX 75230

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name:_____

Address:_____

Telephone H:_____**W:**_____**C:**_____

Additional person(s) authorized to release information to:

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Shirley F.

Telephone: 972-490-4881 Fax: 972-490-1270

Address: 5925 Forest Lane Suite 318 Dallas, TX 75230

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Print Name:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.