Welcome to our Practice!

Ania Mohelicki, D.D.S.

Registration Form

Name (first)_____(middle initial)_____(last)_____
Address_____
City_____State_____Zip_____
Occupation_____ Social Security #_____
Telephone (Home)_____(Work)_____Other Phone#(optional)_____
e-mail address _____ Birth Date_____ Sex: **M F**

□Single □Married □Widowed □Divorced

Employed by_____
If Self Employed, name of business_____
Employer/Business
address_____
_____

□YES □NO Are you a full time student? If so which school?_____
Whom may we thank for referring you? _____

Spouse's name_____
Dependant Children's Names & Ages_____
Person to notify in an emergency _____Relationship:_____
Emergency Phone Numbers_____

I authorize the use of my radiographs and/or photographs for use in seminars and publications of **Dr. Ania Mohelicki**

X_____ Date_____
Signed (patient or parent/guardian if minor)

Must complete if under 18 or full time student/ Responsible Party Information Required

Mother's Name_____ Mother's Social Security#_____
Mother's Address_____
Mother's Home Phone #_____ Birth date_____
Mother's Employer_____ Occupation_____ Work Phone_____
Father's Name_____ Father's Social Security #_____
Father's Address_____
Father's Home Phone #_____Birth date_____ Father's Employer_____
Occupation_____ Work Phone_____

Please note; in cases of divorce, the parent who presents with the child is responsible for payment of that day's services in full. We will be glad to review with you our payment options.

Briefly, state your desires in seeking dental health care._____
_____
What is your *primary* concern that you would like us to address first?_____
When would you like to start treatment?_____ Approximate date of last dental visit?_____

Please complete BOTH sides!

Ania Mohelicki, D.D.S.

Dental History

Are you delighted with your smile? _____

Please rate your smile from 1 to 10 (1=I hate my smile, 10=awesome) _____

Do you now have any unhealed injuries, sores, or growths in or around your mouth? **Y N**

Do you experience regular headaches, or sore and tight muscles in the head & neck? **Y N**

Do your jaws pop, click, lock up, or do you experience difficulty opening? ..... **Y N**

Please circle the following items if you have experienced them

Braces	**Periodontal Disease**	**Tooth Sensitivity to Hot/Cold**
Clenching	**Gum Surgery**	**Reaction to a Local Anesthetic**
Grinding	**Bleeding Gums**	**Treatment for Jaw Joint (TMJ)**
Chipped Teeth	**Chronic Bad Breath**	**Extracted Wisdom Teeth**

Medical History

Are you now, or have you been under a physician's care during the past 5 years?..... **Y N**

If so, when, and for what purpose?_____

How would you rate your Health? (Please check) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you allergic to any foods, medications, drugs, metals, or anesthetics?.....**Y N**

Do you have any lung disorders? (Chronic Cough, pneumonia, emphysema, tuberculosis) **Y N**

Do you, or have you had a heart problem or heart surgery?.....**Y N**

Do you have, or have you had any of the following?

(Please circle)

High Blood Pressure	**Y**	**N**	**Hepatitis or Liver Disease**.....	**Y**	**N**
Mitral Valve Prolapse.....	**Y**	**N**	**Type? A B C Year infected** _____		
Prosthesis (Joint, Implant, Valve)..	**Y**	**N**	**Kidney Disease or Dialysis**.....	**Y**	**N**
Heart Murmur.....	**Y**	**N**	**Thyroid Disease**.....	**Y**	**N**
Pacemaker.....	**Y**	**N**	**Dialysis**	**Y**	**N**
Tumor or Cancer.....	**Y**	**N**	**Arthritis**.....	**Y**	**N**
Stroke or T.I.A.	**Y**	**N**	**HIV or AIDS**	**Y**	**N**
Ulcers	**Y**	**N**	**Immuno-suppression**.....	**Y**	**N**
Epilepsy or Seizures	**Y**	**N**	**Bleeding Problems or Hemophilia**	**Y**	**N**
Asthma.....	**Y**	**N**	**Eating Disorder**	**Y**	**N**
Glaucoma.....	**Y**	**N**	**Rheumatic Heart Disease or Fever**	**Y**	**N**

Do you Smoke or use smokeless tobacco? **Y N** if yes, how much? _____

Is there anything else about your health that should be known? If so, what? _____

_____

Please list all current medications, prescription and over-the-counter, herbs and vitamins:

_____

_____

Please list your primary care physician:_____

Women are you (please circle)

Pregnant	**Trying to become Pregnant**	**Nursing**
Experiencing Hormonal Imbalance	**Taking Hormone Replacement**	**Taking Birth Control Pills**

Signed:_____ Date:_____

The highest compliment our patients can give us is the referral of their friends and family.

Thank you for your trust!

Dr. Ania

Dr. Ania Mohelicki, D.D.S.

Failed Appointment/Cancellation Agreement

So that we may give you the appointment time that best suits your schedule, we ask that you comply with our cancellation/failed appointment policy.

We are committed to keeping your appointment time reserved just for you, and we will do our very best to be consistently on time for that appointment.

If you must change or re-schedule your appointment with us for any reason, please notify our office at least 24 hours prior to your appointment time. If you are scheduled for an appointment on a Tuesday, we ask that you call us by close of business Friday, (2:00 p.m.) as we are out of the office on Mondays. Failure to follow policy could result in a charge which will be added to your account. The minimum charge will be $50.00 per hour of scheduled appointment time, or $25.00 per ½ hour of scheduled appointment time. Payment is expected in full at your next visit.

I have read and understand this agreement

Name _____

Date _____

General Consent Form

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. Drug or chemical reaction. Dental materials and medications may trigger allergic or sensitivity reactions.
2. Long-term numbness (parethesia). Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. Sensitivity in teeth or gums, infection, or bleeding.
5. Swallowing or inhaling small objects.

While we follow procedural guidelines that most often lead to clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement above

_____ _____

Patient's Signature Date

_____ _____

Parent's Signature (If Minor Patient) Date

Dr. Ania

Dr. Ania Mohelicki, D.D.S.

Ania Mokalicki, D.D.S.

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)

_____

_____

_____

DR. ANIA MOHELICKI, D.D.S

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _____, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.