In an effort to learn more about our patient’s preference for contacting us, we would like to ask you to please take a moment and complete this brief survey.

1. How did you learn about Konikoff Dentistry and make the decision to come to our office?
   - ☐ Friend/Family
   - ☐ Konikoff Website
   - ☐ Web Search
   - ☐ TV Commercial
   - ☐ Postcard received in the mail
   - ☐ Office Location
   - ☐ Email
   - ☐ Online Ad (other than a Konikoff website)
   - ☐ Insurance Company

2. Have you ever seen a Konikoff TV commercial?  ☐ Yes  ☐ No

3. Did you use the website to plan your appointment?  ☐ Yes  ☐ No

4. Did you know the Konikoff name prior to making an appointment?  ☐ Yes  ☐ No

5. Did you read reviews online prior to making a decision?  ☐ Yes  ☐ No
   If yes, which one(s)?  ☐ Yelp  ☐ Angie’s List  ☐ Google+  ☐ Facebook  ☐ Demandforce  ☐ Other____________________

6. Did any of our promotions influence your decision to visit us?  ☐ Yes  ☐ No
   If so, which one?  ____________________________________________

7. Did you choose this practice because it’s close to your office or home? Please check one or more.
   - ☐ Home  ☐ Office

8. If you were referred to our office by a person, we would love to thank them.
   Name of Person Who Referred You: ____________________________

9. Additional comments
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Check:</th>
<th>Male ☐</th>
<th>Female ☐</th>
<th>Check Appropriate Box:</th>
<th>☐ Child</th>
<th>☐ Single</th>
<th>☐ Married</th>
<th>☐ Divorced</th>
<th>☐ Widowed</th>
<th>☐ Separated</th>
</tr>
</thead>
</table>

Patient's Social Security # ______________________ Age: _______ Birthdate: ____________

Name: ___________________________________________ Home Phone: ____________________

Home Address: _________________________________ City: ____________________ State: ______ Zip: ______

Email Address: _________________________________ Cell Phone: __________________

Patient's Employer: _____________________________ How Long? ______ Work Phone: ___________

Patient's Employer Address: ______________________ City: ____________________ State: ______ Zip: ______

If Student, Name of School/College _____________________ City: _________________ State: ___ ☐ Part Time ☐ Full Time

Whom May We Thank For Referring You? ____________________________

Person to Contact in Case of Emergency: ____________________________________________________________________ Phone: __________________

**FAMILY INFORMATION**

Spouse / Parent or Guardian Name: __________________________ S.S.# ____________ Birthday: ____________

Address: _______________________________ City: ____________________ State: ______ Zip: ______

Spouse or Parent's Employer: __________________________ Spouse or Parent’s Work Phone: _____________

Spouse / Parent or Guardian Name: __________________________ S.S.# ____________ Birthday: ____________

Address: _______________________________ City: ____________________ State: ______ Zip: ______

Spouse or Parent's Employer: __________________________ Spouse or Parent’s Work Phone: _____________

**DENTAL INSURANCE INFORMATION**

☐ Employee Coverage or ☐ Individual Plan

Subscriber Name: __________________________ Birthdate: ____________

Relationship to Patient: __________________________

Social Security # __________________________ Date Employed ____________

Name of Employer: __________________________ Union or Local # __________ Work Phone ____________

Address of Employer ______________________________ City __________ State ______ Zip ______

Insurance Company Name __________________________ Group # __________ Policy/ID # __________

Insurance Co. Address ______________________________ City __________ State ______ Zip ______

Insurance Co. Telephone Number __________________________

Do you have any additional Dental Insurance? ☐ Yes ☐ No If yes, complete the following:

Subscriber Name: __________________________ Birthdate: ____________

Relationship to Patient: __________________________

Social Security # __________________________ Date Employed ____________

Name of Employer: __________________________ Union or Local # __________ Work Phone ____________

Address of Employer ______________________________ City __________ State ______ Zip ______

Insurance Company Name __________________________ Group # __________ Policy/ID # __________

Insurance Co. Address ______________________________ City __________ State ______ Zip ______

Insurance Co. Telephone Number __________________________
**DENTAL INFORMATION**

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation  Are you in pain? ☐ No ☐ Yes  How Long? _______

Is there anything about your dental needs we should focus on: ________________________________________________

Previous Dentist Name: ____________________________ Phone: (______) ____________

Last Dental exam: ____________________________ Last Dental X-rays: ____________________________

How would you rate your smile?  1  2  3  4  5  6  7  8  9  10

---

**MEDICAL INFORMATION**

Physician ____________________________ Office Phone ____________________________ Date of Last Exam ____________

Pharmacy Name ____________________________ Phone: ____________________________

1. Are you under medical treatment now? ☐ Yes or ☐ No  If yes, please explain ____________________________

2. Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No

If yes, please list ____________________________

3. Have you been told that you need to premedicate with an antibiotic prior to dental treatment? ☐ Yes ☐ No

4. Are you currently taking or have you ever taken any of the following medication either orally or through IV?

☐ Fosamax  ☐ Didrone ☐ Boniva ☐ Aredia ☐ Actonel ☐ Skelid ☐ Zometa

5. Have you had any surgeries? ☐ Yes or ☐ No  If yes, please list: ____________________________

6. Do you have ANY DRUG, LATEX or FOOD ALLERGIES? ☐ Yes or ☐ No  If yes, please list: ____________________________

7. Do you use tobacco? ☐ Yes or ☐ No  How used? ____________________________ How much? ______ How long? ______

8. Have you ever used or are currently using recreational drugs? ☐ Yes or ☐ No

9. FOR WOMEN ONLY: Are you taking Birth Control pills? ☐ Yes or ☐ No

Are you Pregnant? ☐ Yes ☐ No  Approx. Delivery Date _______ Are you nursing? ☐ Yes ☐ No

10. **CIRCLE BELOW IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL CONDITIONS:**

<table>
<thead>
<tr>
<th>Alcohol/Drug Abuse</th>
<th>Diabetes/Hypoglycemia</th>
<th>Hepatitis</th>
<th>Psychiatric Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive Steroid Therapy ♦</td>
<td>Difficulty Breathing</td>
<td>High Blood Pressure</td>
<td>Rheumatic Fever ♦</td>
</tr>
<tr>
<td>Anemia ♦</td>
<td>Emphysema</td>
<td>HIV+/AIDS/ARC ♦</td>
<td>Rheumatoid Arthritis</td>
</tr>
<tr>
<td>Artificial Bones/Joints ♦</td>
<td>Epilepsy</td>
<td>Jaw Problems TMJ</td>
<td>Scarlet Fever ♦</td>
</tr>
<tr>
<td>Artificial Valves ♦</td>
<td>Fainting/Seizures</td>
<td>Joint Replacement ♦</td>
<td>Sinus Problems</td>
</tr>
<tr>
<td>Asthma ♦</td>
<td>Frequent Headaches</td>
<td>Kidney Problems ♦</td>
<td>Stents/shunts ♦</td>
</tr>
<tr>
<td>Bleeding Problems</td>
<td>Frequent Neck Pain</td>
<td>Leukemia</td>
<td>Stomach Ulcers</td>
</tr>
<tr>
<td>Cancer ♦</td>
<td>Glaucoma</td>
<td>Liver Problems</td>
<td>Stroke ♦</td>
</tr>
<tr>
<td>Chemotherapy ♦</td>
<td>Heart Attack ♦</td>
<td>Lupus ♦</td>
<td>Tuberculosis TB ♦</td>
</tr>
<tr>
<td>Chest Pains</td>
<td>Heart Disease ♦</td>
<td>Mitral Valve Prolapse ♦</td>
<td>Venerable Disease</td>
</tr>
<tr>
<td>Congenital Heart Defect ♦</td>
<td>Heart Murmur ♦</td>
<td>Osteoporosis</td>
<td>High Cholesterol</td>
</tr>
<tr>
<td>Defibrillator</td>
<td>Heart Surgery ♦</td>
<td>Pacemaker</td>
<td>Other: _____________</td>
</tr>
</tbody>
</table>

Please notify our office immediately if you have/have had any of the conditions, marked with a ♦. We may need written authorization from your physician to treat you.

♦ X-RAYS - We pride ourselves in delivering the highest standard of care; therefore complete diagnostic x-rays are necessary. We require complete series of x-rays on our new patients. If you have had this series in the past three years we ask that you bring them with you on your initial visit.

♦ Notice to test blood. A law was enacted in Virginia in 1989 which authorized health care providers to test their patients for HIV antibodies when the health care provider is ACCIDENTALLY EXPOSED to blood or body fluids in a manner in which may transmit the human immunodeficiency virus (HIV). However, you would be informed before any of your blood would be tested for HIV antibodies. The testing would be explained and you would be given the opportunity to ask any questions you might have. In addition, in the event that one of our health care providers is exposed to potentially infectious body fluids, permission is hereby granted to test my blood for infectious Hepatitis B.
FINANCIAL INFORMATION – PLEASE READ CAREFULLY

It is the goal of our practice to provide not only the finest care available, but also to provide financial services that do not cause undue hardships. Patients will be scheduled for treatment after financial arrangements are made with our Financial Associates regarding all treatment. OUR FINANCIAL ASSOCIATES ARE AVAILABLE TO ANSWER ANY QUESTIONS YOU HAVE.

Our office requires a 24 hour notice if you are not able to make your appointment. If we do not receive this notice, a fee will be charged to your account.

**X-Ray Requirements** – We pride ourselves in delivering the highest standard of care; therefore, complete diagnostic x-rays are necessary. We require a complete series of x-rays on new patients and patients who have not been to see us on a regular basis. If you have had a series done with another dentist in the past three years, we ask that you bring them with you on your visit. **IF YOU DO NOT HAVE THEM OR ARE NOT ABLE TO RETRIEVE THEM FROM YOUR PRIOR DENTIST BEFORE YOUR APPOINTMENT WITH US, WE WILL NEED TO TAKE X-RAYS AND BILL YOU.**

**Insurance Policy** – The patient is always expected to pay his/her portion at the time of service, including co-pay and deductibles. As a courtesy to all of our patients with insurance, we will file dental services with your primary insurance company, and if applicable your secondary insurance. The normal time allowed for insurance response is 30 days. Any charges remaining on your account after your insurance pays are ultimately your responsibility.

**Payment Policy** – Our office requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the financial department. If other arrangements are made with our finance department, the patient authorizes Konikoff Dental Associates, Inc. to make such inquires with any credit bureau regarding financial responsibilities that are deemed necessary.

**Collection Policy** – If your account becomes delinquent and no financial arrangements have been made, you will be responsible for legal fees, interest charges, 33 1/3% attorney fees, and any other expenses incurred in collecting your account balance. All work must be paid in full at the time of services once your account has been satisfied with the attorney.

**AUTHORIZATIONS FROM PATIENT**

I authorize Konikoff Dental Associates, Inc. to perform any necessary services needed during diagnosis and treatment. I also authorize the release of any required information to outside health practitioners and for the purpose of processing insurance claims.

I understand that my insurance policy is a contract between me and my insurance company(ies) and that I am responsible to Konikoff Dental Associates, Inc. for all fees.

I authorize and request my insurance company (if applicable) to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual billed services and that I am responsible for the remaining balance.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changed to the information I have provided.

**AUTHORIZATION TO RELEASE INFORMATION**

I give permission to release treatment information (past and future), payments and insurance activity to the following:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>DOB:</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

__________________________
Patient Name

__________________________
Signature of Patient (or responsible party)

__________________________
Date
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND SECURITY PRACTICES

I hereby acknowledge I have had the opportunity to review a copy of this office’s Notice of Privacy and Security Practices. (Copies of the privacy policies are located at the front desk)

**You May Refuse to Sign This Acknowledgement**

Please Print Patient Name

______________________________

Patient Signature (or responsible party)

______________________________

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy and Security 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)

________________________________________________________________________

________________________________________________________________________
KONIKOFF DENTAL ASSOCIATES, INC.

APPOINTMENT CANCELLATION AGREEMENT

**Early Arrival Time**

At Konikoff Dentistry, both your time and dental health are very important to us. Every effort is made by our staff to keep on schedule; therefore, we respectfully request that patients be prompt and keep their reserved appointments. Please arrive ten minutes early, so that any changes/updates in your personal status, dental insurance, and/or billing information can be completed prior to your appointment time. Upon completion of this information, if you find that you are waiting more than 15 minutes past your appointed time, please notify the receptionist immediately.

**Late Arrivals**

If you are more than 10 minutes late for your appointment, we ask for your patience in seeing if we can rearrange our schedule to see you. If you think you will be more than 10 minutes late for your appointment, please call us immediately, so that we may advise you if we can rearrange our schedule to still see you, or if we need to reschedule you for a different day. If we must reschedule, a broken/missed appointment fee may be charged based on frequency of this situation and on the services that were being provided to you.

**Broken/Missed Appointments**

If you cannot make an appointment as scheduled, please notify the office at least 24 hours prior to the appointment. Without this 24 hour notification, your account will be charged with a broken/missed appointment fee, which is $50.00 per hour.

I ____________________________ have read and had the opportunity to ask questions and fully understand Konikoff Dentistry’s appointment and cancellation policy.

_____________________________________________  _______________________________________
Patient Signature (or responsible party)                      Date
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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on the above date, 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 provide the new Notice at our practice location, and we will distribute it 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 without authorization for the purposes of treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a doctor 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. For example, 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 the following purposes, 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.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of 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 absence or incapacity or in 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.

Marketing or Sale: We will not use your health information for marketing communications, nor disclose your health information in exchange for remuneration, without your written authorization.

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

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.
Correspondence: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters), correspondence, and missed appointment notification.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting and Breach Notification: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Affected patients have a right to be notified following a breach of unsecured protected health information.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Official, David Quigley, Esq., 6240 Lake Osprey Drive, Sarasota, FL 34240, Ph. #: (941) 955-3150.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.