MEDICAL HISTORY

☐ Mrs. ☐ Miss ☐ Ms. ☐ Mr. ☐ Dr. ☐ Other _____

Name: _____

Address: _____

_____ Zip: _____

Home Phone: _____

Cell Phone: _____

Business Phone: _____

Social Security Number: (last four digits only) _____

Birth Date: _____ Height: _____ Weight: _____

Occupation: _____

Employer: _____

Marital Status: _____

Spouse's Name: _____

Emergency Contact: _____

Phone: _____

Physician: _____

Phone: _____ Date of Last Physical: _____

Dentist: _____

Referred By: _____

NOTE: These questions are for your benefit. This confidential information will assist us in your diagnosis and treatment.

Check any of the following that apply to you:

☐ Heart Trouble	☐ Hemophilia	☐ Hives/Shingles	☐ AIDS/HIV/HPV
☐ Heart Surgery	☐ Anemia	☐ Sinus Trouble	☐ Joint Replacement Prosthesis
☐ Heart Valve Prosthesis	☐ Leukemia	☐ Asthma	☐ Arthritis
☐ Congenital Heart Problems	☐ Sickle Cell Disease	☐ Emphysema	☐ Cancer
☐ Heart Murmur	☐ Kidney Disease	☐ Tuberculosis	☐ Chemotherapy
☐ Rheumatic Fever/Scarlet Fever	☐ Diabetes	☐ Persistent Cough	☐ Cortisone Medicine
☐ Stroke	☐ Thyroid Disease	☐ Epilepsy	☐ Blood Transfusion
☐ High Blood Pressure	☐ Jaundice	☐ Fainting/Dizziness	☐ Psychiatric Care
☐ Glaucoma	☐ Liver Disease/Hepatitis	☐ Herpes/Cold Sores	☐ Drug Dependence
☐ Stomach Ulcers	☐ Sjogren Syndrome	☐ Sexually Transmitted Disease	☐ Child Births

Please list all medications or drugs (including aspirin, vitamins, hormones, antacids, steroids or birth control pills) which you are presently taking or have taken in the last six months (including dose and frequency): _____

Has there been any change in your general health in the last year? _____ Explain: _____

Have you been hospitalized, seriously ill, injured or under a doctor's care during the past two years? _____ Explain: _____

Are you allergic or have you experienced an unusual reaction to any drugs? _____ Please List: _____

Have you experienced excessive bleeding that required special treatment? _____ Explain: _____

Are you required to restrict your diet, work or activities in any way? _____ Explain: _____

Is there a history of Diabetes in your immediate family? _____ Heart Disease? _____ Periodontal Disease? _____

Have you ever been treated for a growth or tumor in any part of your body? _____ Explain: _____

Do you smoke cigarettes? _____ cigars? _____ pipe? _____ How many per day? _____ For how long? _____

Are you under a great deal of stress on a daily basis, or has your daily stress increased? _____

Do you have frequent headaches? _____ migraines? _____ What area of the head? _____ Duration? _____

Please list any disease, condition or problem (not listed) that you feel we should know about: _____

WOMEN: Are you pregnant or nursing? _____ Anticipating Pregnancy? _____ Experiencing menopausal symptoms? _____

Signature: _____ Date: _____

KARL J. ZEREN, D.D.S., LLC
PERIODONTICS AND IMPLANT SURGERY

DENTAL HEALTH HISTORY

Check any of the following which you may have had or experienced:

- ☐ Injury to Face or Jaw
- ☐ Slow Healing Mouth Sores
- ☐ Fever Blisters
- ☐ Mouth Ulcers
- ☐ Swollen Gums
- ☐ Bleeding Gums
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Cold
- ☐ Mouth Odor
- ☐ Bad Taste in Mouth
- ☐ Loose Teeth
- ☐ Change in Bite
- ☐ Aches in Jaw Joint
- ☐ Tired Jaw or Sore Muscles
- ☐ Clicking/Popping in Jaw
- ☐ Jaw Locking – open or closed
- ☐ Root Canal Therapy
- ☐ Orthodontic Therapy

Which of the following do you use on a daily basis?

- ☐ Manual Toothbrush
  Type: _____
- ☐ Electric Toothbrush
  Type: _____
- ☐ Mouthrinse
  Type: _____
- ☐ Fluoride Rinse
- ☐ Floss
- ☐ Proxabrush
- ☐ Other
  List: _____
  _____

If you are currently experiencing pain in your mouth, where is it located? _____

_____

How did it come to your attention that you have a periodontal problem? _____

_____

How do you feel about keeping your teeth for the rest of your life? _____

_____

Are you happy with the appearance of your teeth? _____ If not, what would you change? _____

_____

Have you had previous periodontal (gum) treatment? _____ If so, when? _____

Have you had oral surgery? _____ If so, what type and when? _____

_____

Have you had crown and/or bridgework? _____ If so, when? _____

_____

Have you ever had orthodontic therapy (braces)? _____ If so, when? _____

Have you ever worn a bite guard, bite plane or night guard? _____ Currently? _____

Have you noticed any change in the position of your teeth? _____ Explain: _____

Do you have any difficulty chewing? _____ Explain: _____

Is it difficult to open your mouth wide? _____ Explain: _____

Are you worried about receiving dental treatment? _____ If so, what is your main concern? _____

_____

When was your last dental treatment? _____ For what? _____

Present Dentist: _____ For how long? _____

Last Cleaning: _____ Last X-Rays: _____

Pattern of Dental Care: ☐ Consistent ☐ Sporadic ☐ Infrequent

_____

Signature: _____ Date: _____

_____

Karl J. Zeren, D.D.S.

9515 DEERECO ROAD, SUITE 308
TIMONIUM, MARYLAND 21093
(410) 252-0871

NOTICE OF PRIVACY PRACTICES

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. If you are referred to another practitioner, your healthcare information may be provided in the event you schedule an appointment with that provider of care.

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 incapacity or emergency circumstances, we will disclose health information, using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

To your Family and Friends: We must disclose your health information to you. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree we may do so.

Marketing Health-Related Services: We will not use your health information for marketing communications.

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

Payment: We may use and disclose your health information if it becomes necessary to obtain payment for services we provide to you. Disclosure to third party payers (insurance companies) will occur with your request. Provision of insurance information by you will be considered permission to provide information to your insurance carrier. A request to provide information to your insurance carrier can be altered, in writing, at any time.

Questions and Concerns: If you have a question or concern regarding our privacy policy, please contact the office.

Please assist us in protecting your privacy by providing your preferences (check all that apply):

Confirmation of Appointments: ☐ Do not confirm **OR** Confirm using: ☐ Home phone ☐ Cell phone ☐ Business phone

Voice Mail Messages: ☐ Home phone ☐ Cell phone ☐ Business phone ☐ Request return call only ☐ Details permissible

Family: ☐ Do not discuss ☐ Discuss with spouse _____ ☐ Discuss with _____

NOTE: Inviting someone to accompany you during an appointment, may be considered permission to disclose your health information to that person, as is necessary for care.

Records: ☐ Verbal release acceptable ☐ Written release only

☐ Provide reports to referring physician

☐ Email correspondence between healthcare providers is acceptable.

☐ Do not use email correspondence. (You will transport digital data to and from healthcare providers.)

☐ _____ is authorized to pick up prescriptions, x-rays or other forms of my health information.

SIGNATURE _____ *Date* _____

PRACTITIONER/PATIENT PRIVATE CONTRACT

As this Practioner is not participating in any insurance plan, any fees for services provided will be considered under this private contract between Karl J. Zeren, D.D.S. ("Practitioner"), whose primary practice location is 9515 Deereco Road, Suite 308, Timonium, MD 21093 and you, the Patient/Beneficiary/Legal Representative ("Patient").

_____

Patient Name (printed)

Patient agrees, understands and acknowledges the following:

- Patient is not currently in an emergency or urgent health care situation.
- Patient accepts full responsibility for payment of the Practitioner's fee for all services.
- Insurance company payment will not be accepted by the Practitioner for any items or services furnished by the Practitioner.
- All insurance benefits, if any, will be paid to the patient.
- Insurance limits do not apply to the fee Practitioner may charge.
- Supplemental plans may elect not to make payment for items and services not paid for by your primary insurance carrier.
- Patient agrees to reimburse Practitioner for any costs, collection fees, and reasonable attorney's fees, resulting from violation of this Contract by Patient.
- Patient has the right to obtain covered items and services from practitioners who are participating in their insurance plan(s).
- Patient acknowledges that a copy of this contract has been made available to Patient.

Patient is signing this Private Contract as evidence of his or her understanding and agreement regarding payment for any services to be provided by Practitioner.

_____ Date: _____

Signature of Patient/Beneficiary/Legal Representative

_____

If Representative, Print Name and Relationship

_____

Practitioner Signature: Karl J. Zeren, D.D.S.

PRACTITIONER/PATIENT PRIVATE CONTRACT

As this Practioner is not excluded from participating in Medicare Part B (under sections 1128, 1156, or 1892 or any other section of the Social Security Act), Medicare requires this private contract between Karl J. Zeren, D.D.S. ("Practitioner"), whose primary practice location is 9515 Deereco Road, Suite 308, Timonium, MD 21093 and you, the Patient/Medicare Beneficiary/Legal Representative ("Patient").

_____
Patient Name (printed)

As a Medicare Part B beneficiary seeking services covered under Medicare Part B (pursuant to Section 4507 of the Balanced Budget Act of 1997), Medicare requires you be informed that the Practitioner has opted out of the Medicare program. The anticipated effective date is January 1, 2017 and is estimated to expire January 1, 2019, provided the Practitioner does not extend the opt-out period further.

Patient agrees, understands and acknowledges the following:

- Patient is not currently in an emergency or urgent health care situation.
- Patient accepts full responsibility for payment of the Practitioner's fee for all services
- Medicare payment will not be made for any items or services furnished by the Practitioner, even for those that would have otherwise been covered by Medicare.
- Medicare limits do not apply to the fee Practitioner may charge.
- Medigap plans do not, and other supplemental plans may elect not to make payment for items and services not paid for by Medicare.
- Patient agrees not to submit a claim to Medicare or ask the Practitioner to submit a claim to Medicare, even if such items or services would otherwise be covered by Medicare.
- Patient agrees to reimburse Practitioner for any costs, collection fees, and reasonable attorney's fees, resulting from violation of this Contract by Patient.
- Patient has the right to obtain Medicare-covered items and services from practitioners who have not opted out of Medicare. Patients that receive Medicare covered services, furnished by practitioners who have not opted out, are not compelled to enter into a private contract.
- Patient acknowledges that a copy of this contract has been made available to Patient.

Patient is signing this Private Contract as evidence of his or her understanding and agreement regarding payment for any services to be provided by Practitioner.

_____ Date: _____
Signature of Patient/Medicare Beneficiary/Legal Representative

_____
If Representative, Print Name and Relationship

_____
Practitioner Signature: Karl J. Zeren, D.D.S.