**PATIENT INFORMATION**

**PATIENT** DATE _____

Mr. / Mrs. / Ms / Dr.

Last Name _____ First Name _____ MI _____

SS#_____Birthdate_____Age_____ Gender_____ married / single /divorced

Address_____City_____State____ Zip_____

Phone: Home (_____)_____ Work (_____)_____ Mobile (_____)_____

Email: _____ Referred By: _____

(By providing your email address, you grant DR. BERNARD KRUPP, DDS, OMS, PA permission to contact you)

Employer_____Occupation_____

Address_____City_____State____ Zip_____

Closest relative not living with you _____ Relationship:_____ Phone (____)_____

Emergency Contact _____ Phone (____)_____

General Dentist _____ Phone (____)_____

Physician _____ Phone (____)_____

Specialist _____ Phone(____)_____

**GUARANTOR/ LEGAL GUARDIAN INSURANCE INFORMATION**

Mr. / Mrs. / Ms / Dr

Last Name _____ First Name _____ MI _____

Address _____ Relationship to Patient _____

City _____ State _____ Zip Code _____

Phone: Home (_____)_____ SS# _____ Birth Date _____

Employer _____

Address_____City_____State____ Zip_____

Phone: Work (_____)_____ Ext. _____ Driver's Lic. # _____

Dental Insurance _____ Policy # _____ Gr. #: _____

Dental Insurance _____ Policy # _____ Gr. #: _____

Medical Insurance _____ Policy # _____ Gr.#: _____

Medical Insurance _____ Policy # _____ Gr.#: _____

Are you currently or have you ever been involved in a malpractice lawsuit?.....Y N If Yes, explain: _____

**ACKNOWLEDGEMENT**
**RECEIPT OF NOTICE OF PRIVACY PRACTICES**
**By my signature below, I acknowledge receipt of the provider's Notice of Privacy Practices.**

_____

Patient's (or legal guardian's) signature Date

# SNORING QUESTIONNAIRE

If you snore, you are very familiar with the impact that lack of sleep has on your quality of life. Snoring not only disrupts sleep, but it may also be a sign of a serious condition called Obstructive Sleep Apnea (OSA). To find out if you should be concerned about your snoring, choose a number from the scale below that best describes your snoring in each situation.

0 = Never
1 = Infrequently (1 night per week or less)
2 = Frequently (2 – 3 nights per week)
3 = Most of the time (4 or more nights per week)

| **Situation** | **Your Score** |
|---|---|
| My snoring affects my relationship with my partner | 0 1 2 3 |
| My snoring causes my partner to be irritable or tired | 0 1 2 3 |
| My snoring requires us to sleep in separate room | 0 1 2 3 |
| My snoring is loud | 0 1 2 3 |
| My snoring affects other people when I am sleeping away from home(hotel, camping, etc.) | 0 1 2 3 |

Total Score _____

**If you scored 5 or greater, your snoring is affecting your quality of life and relationships.** You should consider discussing treatment options available for your snoring with your doctor.

# SLEEPINESS QUESTIONNAIRE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the scale below to choose the most appropriate number for each situation:

0 = Would never doze off or fall asleep
1 = Slight chance of dozing off or falling asleep
2 = Moderate chance of dozing off or falling asleep
3 = High chance of dozing off or falling asleep

| **Situation** | **Your Score** |
|---|---|
| Sitting and Reading | 0 1 2 3 |
| Watching Television | 0 1 2 3 |
| Sitting inactive in a public place (movie theater) | 0 1 2 3 |
| As a passenger in a car for an hour without a break | 0 1 2 3 |
| Lying down to rest in the afternoon | 0 1 2 3 |
| Sitting and talking to someone | 0 1 2 3 |
| Sitting quietly after lunch without alcohol | 0 1 2 3 |
| In a car while stopped for a few minutes in traffic | 0 1 2 3 |

Total Score _____

**If you scored 6 or greater, you may have a sleep disorder.** You should consider discussing treatment options available for your snoring with your doctor.



Bernard I. Krupp DDS
1220 E. Joppa Road, Suite 314 - Towson, MD 21286 | 20 Crossroads Drive, Suite 106 - Owings Mills, MD 21117
800.255.1286 | www.kruppcenter.com

## HEALTH HISTORY

Patient Name: _____ Today's Date: _____ / ____ /_____ Surgicenter: Towson / Owings Mills

1. Are you in good health? .....Y N
2. Height _____ Weight _____
3. Has there been any change in your general health in the past year? .....Y N
4. Date of last physical exam _____
5. Date of last eye exam? _____
6. Are you now under a physician's care for a particular problem? .....Y N
7. Have you **ever** had any serious illnesses or hospitalizations? If so, describe: .....Y N

_____

_____

_____

_____

B. Antibiotics (Penicillin, Amoxicillin, etc) ..... Y N
C. Sedatives, Barbiturates? ..... Y N
D. Aspirin or Ibuprofen? ..... Y N
E. Codeine or other pain killers? ..... Y N
F. Latex or Rubber Products? ..... Y N
G. Sulfa, Iodine? ..... Y N
H. Skin rash to plastic or bandage? ..... Y N
I. Collagen/Bovine? ..... Y N
J. Eggs ..... Y N
K. Other allergies or reactions? Please, list ..... Y N

_____

_____

_____

_____

**8.** Do you need to pre-medicate prior to dental work? (TAKE AN ANTIBIOTIC).....Y N

**9. DO YOU TAKE ANY ANTICOAGULANTS?** .....Y N

**Please Circle: Coumadin, Plavix, Heparin, Aspirin, Other** _____

**If yes, provide name and phone number of prescribing doctor:** _____

1. Are you taking **<u>any</u>** drugs for osteoporosis including **Reclast (yearly injectable) or Fosamax** .....Y N
2. List **<u>all</u>** medications you are currently taking including over-the-counter medications, vitamins and herbal supplements, dosage and frequency they are taken:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**3. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

A. Local Anesthesia (Novocaine, etc.)?.....Y N

4. Do you smoke or chew Tobacco? ..... Y N
How much per day? ..... How Long? _____
5. Is there any past history of Alcohol or Chemical Dependency, Habit Forming Drugs or Emotional Disorder that may affect the care we provide you? ..... Y N
6. Have you had any serious problems associated with any previous dental treatment? ..... Y N
7. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
8. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
9. Do you wish to talk to the doctor privately about anything? ..... Y N

**10. FOR WOMEN ONLY**

A. Are you pregnant, or is there **<u>any chance</u>** you might be pregnant? ..... Y N
B. Are you nursing? ..... Y N
C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

## HEALTH HISTORY

***PLEASE CIRCLE ALL CONDITIONS WHICH YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:***

Congenital Heart Disease
Mitral Valve Prolapse
High/Low Blood Pressure
Angina
Heart Surgery
Chest Pain
Emphysema
Bronchitis
Breathing Problems
Asthma
Arthritis
Swollen Ankles
Seizure/ Convulsions
Fainting or Dizziness
Bleeding Disorder
Blood Transfusion
Coronary Artery Disease
Heart Murmur
Irregular Heart Beat
Heart Attack/Stroke
Pacemaker
Shortness of Breath
Lung Disease
Tuberculosis
Pneumonia
Chronic Cough
Thyroid Disease/Goiter
Diabetes
Epilepsy
Leukemia
Excessive Bleeding
Anemia
Sickle Cell Trait or Disease
Liver Disease
Hepatitis
Kidney Disease or Surgery
Stomach Ulcers/Colitis
Glaucoma/Eye disease
Allergy/Hay Fever
Cancer
Radiation
Artificial Implants Placed
TMJ Pain
Cold Sores/Fever Blisters
Sexually Transmitted Disease
Dementia
Rheumatic Fever
High Cholesterol
Blood Clots
Jaundice
Back Problems
Gallbladder Problems
Contact Lenses
Sinus Problems
Nose Bleeds
Chemotherapy
Malignant Hyperthermia
Joint Replacements
Clicking/Popping of Jaw
Contagious Disease
Habit Forming Drugs
Mental Health Problems
Infectious Mono

***PLEASE LIST ANY SURGERIES YOU HAVE HAD:***

| OPERATION | SURGEON | YEAR |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

A. Did you have a normal recovery? Y N
B. Were there any complications? Y N
C. If yes, please explain:

_____
_____
_____

D. If you had cosmetic / dental implant surgery before, were you satisfied with the results? Y N
E. If no, please explain:

_____
_____
_____

***INDICATE THE AREAS YOU WOULD LIKE TO DISCUSS DURING YOUR VISIT.***

☐ Dental implants
☐ Jaw Surgery
☐ TMJ (Temporo-Mandibular Joint)
☐ Breathing / Snoring

**Non-Surgical Procedures**

☐ Skin Care / Microdermabrasion
☐ Lip / Facial Augmentation
☐ Wrinkle Reduction
☐ Chemical Peels
☐ Laser Skin Resurfacing

**Aesthetic Surgery**

☐ Brow Lift
☐ Eyelid Surgery
☐ Face/Neck Lift
☐ Rhinoplasty (nose)
☐ Facial Liposuction
☐ Chin Implant
☐ Facial Implants
☐ Protruding Ear Surgery
☐ Scar / Mole removal

**COSMETIC PATIENTS, PLEASE ANSWER THE FOLLOWING:**

I authorize Dr. Bernard Krupp and his associates to take my facial photos for diagnostic/treatment planning purposes and understand that the alterations of these facial images are purely for the purpose of illustration and discussion and that the outcome of the surgical procedure is related to my individual healing characteristics. I also acknowledge that there is **no warranty or guarantee** expressed or implied as to my final appearance by the use of the computerized imaging device.

x _____ _____

Signature of Person Completing Health History | Date

A. What specifically would you like to have corrected? _____

B. How long have you been dissatisfied with this part of your appearance? _____

C. When did you begin to consider surgical correction? _____

D. Why have you decided to have it corrected now? _____

E. Do you think about it a lot? ..... Y N

F. Have you consulted another doctor about this surgery? ... Y N If Yes, When? Surgeon? .....

G. Have you discussed this with your family? ..... Y N Are they supportive? ..... Y N

H. Has anyone else in your family or a close friend had cosmetic surgery? .....Y N

.....Surgery?

a. What was done? Surgeon? _____

## All Patients Must Read and Sign Below:

**I certify that I have read and understand the above questions. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. In addition, I understand that Bernard Ian Krupp, D.D.S. is a Board Certified Oral and Maxillofacial Surgeon who emphasizes cosmetic facial surgery and dental implant surgery. I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.**

x _____ _____ _____

Signature of Person Completing Health History | Date | Doctor's Initials

x _____ _____ _____

Health History Reviewed By | Date | Doctor's Initials

**Medical Update:** I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

_____

Updated Exceptions or changes

_____ _____ _____

Date | Patient's Signature | Doctor's Signature

_____

Updated Exceptions or changes

| Date | Patient's Signature | Doctor's Signature |
|---|---|---|

# Important Information for Our Patients

Understanding your insurance coverage can be quite challenging; our goal is to assist you in maximizing your benefits. Insurance companies rarely reimburse the full amount, usually paying between 50% and 80% of the cost. Our office quotes current fees that are within usual and customary range of Oral and Maxillofacial surgery offices in our area, while many companies pay a set fee schedule that is often outdated. We encourage you to become familiar with policy benefits, exclusions, deductibles and required co-payments.

***Our courtesy to you includes:***

1. Filing your insurance in a timely manner according to membership information you have provided us and requested payment of your benefit to our office if the plan is one that our office works with directly.
2. Filing your insurance claim as a courtesy on your behalf in a timely manner according to the information you have provided us and request any payment to be sent to you directly at the home address provided if your plan is one that our office does not work with directly.

***Our expectations of you as the owner of the policy:***

1. Payment of fees not covered by your insurance plan and payment of all coinsurance is due at the time services are rendered if your plan is one that we are working with directly. If we are not working with your plan directly, payment is due at the time of service and we will file your claim as a courtesy on your behalf.
2. Understanding your insurance is a contract between you, your employer, and the insurance company. We are not a party of this contract.
3. Keeping our office informed of any changes in your insurance coverage, address, phone number, or employment.
4. You may elect to have your insurance billed. If insurance is billed, global cosmetic fees are voided and each procedure is billed appropriately. You, then, become responsible for co-pays, coinsurance and un-reimbursed fees.
5. In cases of divorced parents, the parent that brings the child will be deemed responsible for co-pays.
6. **If you are unable to keep your surgical appointment and do not provide our office with 24 hours notice, a surgical set up fee will be assessed and billed to you according to the amount of time reserved on our schedule.**
7. **If you miss an appointment and do not provide our office with 24 hours notice, a missed appointment fee of $100 will be charged and due prior to scheduling another appointment.**
8. **If your procedure requires pre-authorization and an approval is given by your insurance plan, this is not a guarantee of payment.**

We are committed to providing you with the best possible care. If you **do not have medical or dental insurance**, we will work closely with you to inform you of cost of all treatment prior to work commencing. In order to achieve these goals, we need your assistance and your understanding of our payment policy. If you have any questions about the above information, please do not hesitate to ask. We are here to help.

I hereby authorize the release of pertinent information to my insurance company and any other doctors involved in my case. If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court cost, and attorney fees. I understand that all accounts with a balance over 30 days shall accrue an administrative fee of $10.00 per month or 1.5% of the outstanding balance, whichever is greater.

If the office works directly with my insurance plan, I authorize my benefits to be paid directly to Dr. Bernard I. Krupp, DDS and acknowledge that I am financially responsible for any balance which is not paid by my insurance after 90 days. I authorize 'DR BERNARD KRUPP, DDS, OMS, PA' to release any information acquired during my examination and treatment to my insurance company.

I, _____ (SEAL), have read the above stated financial policy of 'DR BERNARD KRUPP, DDS, OMS, PA' and understand and accept my obligation. (Parent's signature if minor)

_____ _____

Witness Signature Date



Bernard I. Krupp, DDS
1220B E Joppa Rd, Ste 314 - Towson, MD 21286 | 20 Crossroads Dr, Ste 106 - Owings Mills, MD 21117
800.255.1286 | www.kruppcenter.com

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

DR. BERNARD I. KRUPP is committed to your personal well being. Protecting the privacy and security of the information you share with us in included in that commitment. While we don't sell or trade any information to third parties, we do share information with entities as part of our routine and necessary business operations such as your insurance company. We do this with the utmost care and confidentiality.

This notice is being provided to explain how your personal healthcare information (PHI) is used and your rights to review, amend, and or/request limitations on the disclosure of this information.

**I. Your Rights to Privacy and Disclosure:**

You have the Right to request restrictions of uses and disclosures of your Protected Health Information as outlined below, although there are some instances where we are not required to agree to a requested restriction.

A. At your initial appointment, you may request that our office restrict the use or disclosure of your protected health information to carry out treatment, payment, or healthcare operations. To request a restriction of your information, please contact our office and explain that you want to restrict the release of all or part of your information.

B. You can request to receive confidential communications concerning your health information. To receive your information confidentially, contact our office and direct us to where you would like to receive your information.

C. You can inspect and obtain a copy of your medical record unless otherwise protected by law. Contact our office to make that request.

D. You can obtain a copy of this Notice at any time. You will receive one at your initial appointment.

E. You can amend your protected healthcare information/medical record by contacting our office. We cannot destroy or otherwise remove the original information, but may add/amend information in your medical record pursuant to our policy.

F. You can request an accounting of our disclosures of your medical records unless protected by Law, by contacting our office.

**II. Definitions:**

A. Disclosure means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

B. Healthcare means care or services related to the health of an individual. Healthcare includes, but is not limited to, diagnostic, therapeutic, rehabilitative care and/or the sale or dispensing of a drug, equipment, or other item in accordance with a prescription.

C. Protected Health Information means any individually identifiable health Information, whether oral or recorded in any form, that is created and relates to the past, present, and future physical or mental health, condition or care of an individual.

**III. Permitted Disclosures:**
DR. BERNARD I. KRUPP may not use or disclose protected health information, excepted as permitted or required by law. The following are permitted uses and disclosures under current Laws. The following are permitted uses and disclosures under current Laws. We can release information to the following unless otherwise restricted by law:

(i) to the patient the information pertains to or his/her representative
(ii) to DR. BERNARD I. KRUPP, DDS, OMS, PA business associates or other healthcare providers, to carry out treatment, payment, or healthcare operations purposes;
(iii) to anyone in compliance with an authorization completed by the patient or patient's representative
(iv) to others as permitted by and in compliance with some other law or regulation. For example, those that require reports, Maryland's Department of Health and Mental Hygiene.

Individually identifiable health information is shared with entities for purposes related to the function and operation of a physician practice:

- Consulting Physicians
- Managed care organizations
- Health insurance companies
- Health benefit managers
- State/Federal Agencies
- Clinical laboratories

This information is released for the sole purpose of ensuring continuity of care, billing, and conducting quality assessment and improvement activities which review the competence or qualifications of healthcare professionals.

We may also use this information to confirm your scheduled appointments, inform you about treatment alternatives, or to inform you of other health related benefits and services.

The Federal Health Insurance Probability and Accountability Act (HIPPA) established guidelines that require DR. BERNARD I. KRUPP to maintain the privacy of your protected health information (PHI). HIPPA also requires us to provide you this Notice of Privacy Practice and our legal duties with respect to your health information. Further, DR. BERNARD I. KRUPP as well as his agents are required to abide by the terms of this Notice DR. BERNARD I KRUPP does, however, have the right to change the terms of this Notice and to make the Notice provisions effective for all protected health information (PHI) that we maintain. In the event that we do make changes to the current Notice, we will make the changes apparent in the Notice, post the changes in our waiting room, and include them on our website. We will not notify every past patient individually, but will attempt to abide by the requirements of the Notice at the tome of your healthcare.

**IV. Questions or Complaints**

Should you have any questions or concerns about this Notice, you can contact our Privacy Officer at 410-583-7600.

You may file a complaint or grievance in relation to any portion of this Notice's provisions. It will be reviewed under the terms of our grievance process. You will not be subject to any retaliation for filing a complaint. You may also file a complaint to the Secretary of Health and Human Services in Washington, DC.

To file a complaint/grievance with DR. BERNARD I. KRUPP please contact our Privacy Officer at 410-583-7600.

**V. Effective Date:**

The provisions set forth in this Notice have been in effect since March 1, 2003.
This Notice is provided to you on behalf of DR. BERNARD I. KRUPP



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