Michael H. Kessler D.D.S., PA
220 Third Avenue South | Jacksonville Beach, FL 32250
(904) 249-9069 | dr.mhkessler@gmail.com

WELCOME TO OUR PRACTICE

Office Hours

Monday – Thursday
8am to 5 pm
Friday appointments available on per case/treatment basis **

Parking

Parking is available at our building, with access on Third Avenue South. Street parking is also available on each street surrounding our location.

Appointments

We know there are times when you cannot keep your appointment. If this happens, we require a 2 business days' notice so we may utilize this time for another patient.

Web Page

Please check our web page **http://www.michaelkesslerdds.com/** for answers to most of your questions. In addition, you can print out the new patient packet from our web site and bring them with you to your first appointment. Please call us for any further questions.

Location

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Patient Information

Date_____

Last name_____First name_____Middle Initial_____

Address_____

Telephone (home)_____(cell)_____(work)_____

E-mail_____

Date of Birth_____SS#_____

Circle: Male Female Marital Status: Married Single Other

Employer_____No. years employed_____

Address_____

Primary Insurance - Dental

Last name_____First name_____Middle Initial_____

Address_____

Last name of Policyholder_____First name_____Middle Initial_____

Date of Birth_____Relationship to patient_____

Insurance Company_____

Address_____

Subscriber ID#_____Subscriber SS#_____Group #_____

Secondary Insurance - Dental

Last name_____First name_____Middle Initial_____

Address_____

Last name of Policyholder_____First name_____Middle Initial_____

Date of Birth_____Relationship to patient_____

Insurance Company_____

Address_____

Subscriber ID#_____Subscriber SS#_____Group #_____

Patient Information

Last name_____First name_____Middle Initial_____

Person to contact in case of an emergency

(Outside of immediate family household)

Last name_____First name_____Middle Initial_____

Address_____

Telephone_____Relationship to patient_____

Method of payment

Name of responsible party for this account_____

Type of payment at time of appointment (Cash)____(Check)____(Visa)____(MC)____(Other)_____

Card #_____Exp. Date_____Security Code_____

Whom may we thank for referring you to our office?_____

Service Charge

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest of the balance due, together with any collection of this account or future outstanding accounts.

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostics, photographic and therapeutic procedures as may be necessary for proper dental care. The information provided are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical history and other information about my dental treatment to third party payers and/or other health professionals.

Signature of responsible party_____Date_____

Print signature name_____

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MEDICAL HISTORY

Patient Name:_____ **Date of Birth:**_____

Physician's Name_____ **Physician's Phone**_____

Please check the box for any condition which you have had in the past or have now. Parents or Guardian, if you are completing this form for your child, please indicate your child's health status by checking the appropriate boxes.

CARDIOVASCULAR

- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Angina or Chest Pain
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Congenital Heart Defect
- ☐ Artificial Heart Valve
- ☐ Have Taken Phen-Fen
- ☐ Arrhythmias
- ☐ Heart Pacemaker
- ☐ Coronary By-Pass/Angioplasty
- ☐ Heart Transplant
- ☐ Aneurysm
- ☐ Other Heart Problem _____

PULMONARY

- ☐ Sinus Trouble /Hay Fever
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Tuberculosis (TB)
- ☐ Breathing Difficulties

ALLERGIES

- ☐ Allergy to Local Anesthetic
- ☐ Allergy to Latex (Rubber)
- ☐ Allergies or Hives
- ☐ Aspirin/Acetaminophen/Ibuprofen Allergy
- ☐ Nitrous Oxide Allergy
- ☐ Erythromycin Allergy
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Other Allergy _____

ENDOCRINE / NEUROLOGIC

- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Taking any Steroid
- ☐ Vision Problems
- ☐ Glaucoma
- ☐ Earaches, Ringing in Ears
- ☐ Severe Headaches
- ☐ Fainting or Dizzy Spells
- ☐ Stroke
- ☐ Epilepsy or Seizures
- ☐ Psychiatric Treatment
- ☐ Nervous Disorders
- ☐ Panic Attacks
- ☐ Phobias
- ☐ Head Injuries
- ☐ Mild Cognitive Deficiency
- ☐ Dementia or Alzheimer's

GASTROINTESTINAL

- ☐ Stomach/ Intestinal
- ☐ Persistent Diarrhea
- ☐ Eating Disorders
- ☐ Ulcers
- ☐ Colitis / Chrons
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Cirrhosis

DERMAL / MUSCULOSKELETAL

- ☐ Skin Rash
- ☐ Changes in dark mole appearance
- ☐ Night Sweats
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Systemic Lupus
- ☐ Artificial (Prosthetic) Joint

HEMATOLOGIC

- ☐ Blood Transfusion
- ☐ Anemia
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Sickle Cell Anemia
- ☐ Bruise Easily
- ☐ Prolonged Bleeding

GENITOURINARY

- ☐ Urinate Frequently
- ☐ Kidney, Bladder Problem
- ☐ Kidney Disease
- ☐ Kidney Transplant
- ☐ Dialysis
- ☐ AIDS / HIV Positive
- ☐ Sexually Transmitted Disease (Syphilis, Gonorrhea, Chlamydia or Genital Herpes)

LIFESTYLES

- ☐ Use Tobacco
- ☐ Use Alcohol
- ☐ Use of Recreational Drugs
- ☐ Drug or Alcohol Addiction (Recovering or Current)

OTHER CONDITIONS

- ☐ Currently Pregnant

Due Date _____

- ☐ Nursing
- ☐ Frequent Sore Throats
- ☐ Enlarged Lymph Node or "Gland"
- ☐ Tumor or Cancer
- ☐ Radiation Therapy
- ☐ Chemotherapy /Other Condition Not Listed

_____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE.

1. **YES NO** **Have you been under a physician's care, admitted to a hospital or needed emergency care during the past five years?**

   Describe the situation and any complications.

_____

_____

_____

2. **YES NO** **Have you ever had any operations or surgeries?**
   Please describe the surgery.

_____

_____

3. **YES NO** **Have you ever had any severe reaction to any dental treatment or local anesthetics?**

4. **YES NO** **Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint?**

5. **YES NO** **Do you take any medications, including birth control pills, over the counter, vitamins, supplements or herbals?**

   Please specify name and purpose of medications.

_____

_____

_____

_____

I certify that the answers to the health questions are accurate and correct to the best of my knowledge.

Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes in my health status at any subsequent appointments.

I authorize Michael H Kessler, DDS to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Kessler to make a thorough diagnosis of the patient's dental needs. I also authorize Michael H Kessler, DDS to perform any and all forms of treatment, medication and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk.

_____ _____

Signature of patient or responsible party **If responsible agent, relationship to patient**

_____

Date

Reviewed by Doctor: _____ **Date:**_____

Blood Pressure: _____

FOR OFFICE USE ONLY -- MEDICAL HISTORY ANNUAL REVIEW & DATE TRACKING

Med. Hx Review Date	Med. Hx Review Date	Med. Hx Review Date
Med. Hx Review Date	Med. Hx Review Date	Med. Hx Review Date
Med. Hx Review Date	Med. Hx Review Date	Med. Hx Review Date

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DENTAL HISTORY

Name_____Age_____
How would you rate the condition of your mouth? □Excellent □Good □Fair □Poor
Previous Dentist_____ How long had you been a patient? _____
Date of most recent dental exam_____ Date of most recent x-rays_____
I routinely see my dentist every: □3 mo. □4 mo. □6 mo. □12 mo. □Not routinely
What is your immediate concern?_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)? [ ]		
Have you had an unfavorable dental experience?		
Have you ever had complications for past dental treatment?		
Have you ever had trouble getting numb or had any reactions to local anesthetic?		
Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?		
Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?		
GUM AND BONE		
Do your gums bleed or are they painful when brushing or flossing?		
Do you brush less than twice a day? I floss once per ☐day ☐week ☐month ☐year ☐never		
Have you ever been treated for gum disease or been told you have lost bone around your teeth?		
Have you ever noticed an unpleasant taste or odor in your mouth?		
Is there anyone with a history of periodontal disease in your family?		
Have you ever experienced gum recession?		
Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?		
Have you experienced a burning or painful sensation in your mouth nor related to your teeth?		
TOOTH STRUCTURE		
Have you had any cavities within the past 3 years?		
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?		
Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?		
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?		
Do you have any grooves or notches on your teeth near the gum line?		
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?		
Do you frequently get food caught between any teeth?		
BITE AND JAW JOINT		
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)		
Do you feel like your lower jaw is being pushed back when you try to bite your teeth together?		
Do you avoid or having difficulty chewing gum, carrots, nuts, bagels, or other hard, dry foods?		
In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?		
Are your teeth becoming more crooked, crowded, or overlapped?		
Are your teeth developing spaces or becoming looser?		
Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?		
Do you place your tongue between your teeth or close your teeth against your tongue?		
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?		
Do you clench or grind your teeth together in the daytime or make them sore?		
Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness or your teeth?		
Do you wear or have you ever worn a bite appliance?		
SMILE CHARACTERISTICS		
Is there anything about the appearance of your teeth you would like to change (shape, color, size)?		
Have you ever whitened (bleached) your teeth? Or like a whiter smile?		
Have you felt uncomfortable or self-conscious about the appearance of your teeth?		
Do you have existing crowns or dental work, which you consider ugly?		

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CONSENT FOR USE AND DISCLOSURE OF HEALTH

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Michael H Kessler, DDS, PA. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Michael H Kessler, DDS, PA reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐ YES	☐ NO
SPOUSE ONLY	☐ YES	☐ NO
OTHER (PLEASE SPECIFY)	☐ YES	☐ NO

_____ _____

Name of Patient or Personal representative

Signature of Patient or Personal representative

_____ _____

Date

Description of Personal representative

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice but was unable to do so as documented below.

Initials_____ Date _____

Reason

_____

_____

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VIP EXPRESS CHECKOUT & RECURRING PAYMENT AUTHORIZATION

We pride ourselves with the high level of care we provide all our patients. As a convenience to you, this information will allow us to apply any balances on your account for services rendered (co-insurance, deductibles, etc.) at the time of service and balance after insurance payments to your credit card. A statement will be sent notifying you of the charge. Just complete, sign and return this form to Michael Kessler, DDS to get started.

Please complete the information below:

I authorize Michael H Kessler, DDS, PA to charge my credit card indicated below on or around the 1st day of each month in the amount due each month unless a financial arrangement has been approved. **

Account Name:_____

Account Email:_____

Account Phone:_____

Account Address:_____

CREDIT CARD INFORMATION					
Card Type	VISA	MASTERCARD	AMEX	DISCOVER	DEBIT
Card Holder Name					
Billing Address					
City, State, Zip					
Card Number					
Expiration Date			CVV		

** PRIOR FINANCIAL ARRANGEMENT

Alternate billing date_____

Recurring monthly payment amount_____

Other arrangement_____

Approved by_____

I authorize Michael H Kessler, DDS, PA to charge the credit card indicated above in this authorization form according to the terms outlined above. If the 1st day of the month falls on a weekend or holiday, I understand that the payments may be executed on the next business day. This payment authorization is to remain in full force until I notify Michael H Kessler, DDS, PA of its cancellation by sending a written notice in such time and manner to allow Michael H Kessler, DDS, PA a reasonable opportunity to act on it. I agree to notify Michael H. Kessler, DDS, PA in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for payment of service rendered of any patient on the account indicated above due to Michael H Kessler, DDS, PA. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Signature_____Date_____

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STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTH INFORMATION We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Florida. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone— even family members—without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail, text messaging, answering machines, and postcards.

PATIENT RIGHTS You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge you for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient in our practice. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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FINANCIAL POLICY

For all patients, we will expect payment at time of treatment.

For treatment covered by insurance, we will ask for payment of the portion of fees not covered by insurance at the time of your procedure.

METHODS OF PAYMENT:
All payments must be made in U.S. dollars. Acceptable methods of payment are cash, check, Visa, Mastercard, American Express, Discover, CareCredit, or debit cards.

INSURANCE:
As a courtesy, we will bill your insurance company if provided with all the proper billing information. Insurance is a contract between you and your insurance company. Although we will do the best of our ability to estimate what your insurance company may pay, it is the insurance company that makes the final determination of eligibility. All accounts are due within 60 days, regardless of insurance involvement. A 1.5% monthly finance charge will be assessed on all accounts past 60 days.

MONTHLY STATEMENTS:
If there is a balance owing on your account, we will send you a monthly billing statement. It will show separately a previous balance along with any new charges or payments made to your account. In the event that your account has a credit balance, we generally issue refunds to the appropriate party within two weeks of the payment which created the credit.

RETURNED CHECKS:
There is a $30.00 fee for any checks returned by the bank.

MISSED APPOINTMENT:
Patients who do not show up for an appointment or cancel with less than 2 business days' notice will be charged a $50.00-$75.00 cancellation fee depending upon the circumstances and the scheduled length of the missed appointment.

PAST DUE ACCOUNTS:
If your account becomes past due, we will take necessary steps to collect the debt. Accounts that are exceptionally delinquent will be sent to collections. We appreciate your effort to keep your account current.

Please feel free to ask any questions you may have regarding these policies. We are most willing to help you in any way we can.