Craig A. Zunka, DDS
107 W. 4th Street
Front Royal, VA

TODAY'S DATE: _____

Welcome!

In order to provide you with the best possible care please complete both sides of this form. All information is completely confidential.

PATIENT INFORMATION: *PLEASE PRINT*

Name: _____
Last *First* *Middle Initial*

Name you prefer to be addressed by: _____

Mailing address: _____

Residence *(If different than your mailing)*: _____

Home Telephone #: ( ) _____ Business #: ( ) _____ Email: _____

Patient's Date of Birth: ___/___/___ Patient's Social Security #: ___/___/___

Employer: _____ Employer's Address: _____

SPOUSE INFORMATION: *PLEASE PRINT*

Spouse's Name: _____
Last *First* *Middle Initial*

Spouse's Social Security #: ___/___/___ Employer _____

Employer's Address: _____

Employer's Telephone #: ( ) _____ Date of Birth: ___/___/___

IF THE PATIENT IS A MINOR... *(If Applicable)*

_____ _____
Father's Last Name *First Name* *Mother's Last Name* *First Name*

Father's SS#: ___/___/___ Mother's SS#: ___/___/___

Father's Date of Birth: ___/___/___ Mother's Date of Birth: ___/___/___

Father's Employer: _____ Mother's Employer: _____

Employer's Address: _____ Employer's Address: _____

Employer's Telephone #: ( ) _____ Employer's Telephone #: ( ) _____

How did you hear of Dr. Zunka? _____

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a through diagnosis of (name of patient)_____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient's Signature_____ Date_____

Parent/Responsible Party's Signature_____ Relationship to Patient _____

NOTICE TO ALL PATIENTS!!! Dr. Zunka **does not participate with any insurances, this includes Medicare and Medicaid. We are not a Medicare provider.** WE ARE OUT OF NETWORK. All treatment incurred from this office must be paid at the time service is rendered. Your signature on this form is indication that you have been notified according to Medicare and Federal regulations.

DENTAL HISTORY

What is the reason for your visit today? _____

_____

Date of Last Dental Visit?_____Last Dental Cleaning?_____Full Mouth X-rays? _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address_____State_____Zip_____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth?_____How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes / No

If yes, please describe: _____

Would you like to keep all your teeth? Yes / No Nervous about dental treatment? Yes / No

Why? _____

PLEASE CIRCLE ALL THAT APPLY (PAST OR RECENT)

Bad Breath/Taste

Bleeding Gums/Pain

Sensitive to Hot

Sensitive to Cold

Sensitive to Sweets

Orthodontics—past/present

Mouth Pain

Mouth Breathing

Fingernail Biting

Burning On Tongue

Serious injury to mouth or head

Lip or cheek chewing

Cigarette, cigar smoking, chewing tobacco & snuff

Dental Implants

Headaches/Neck aches/Shoulder aches

Grinding teeth/Clenching teeth

Difficulty opening/closing

Jaw pops or clicks

Jaw Pain

Sores or growths in mouth

Loose or broken teeth

Mouth guard or bite plate

Periodontal treatment

Family history of Periodontal Disease

Chewing on one side only

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe _____

_____

_____

Date:

Medical Alerts: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

→→Please CIRCLE YES or NO for all. ←←

ALLERGIES: Are you allergic to or had a reaction to any of the following?

Yes/No Local Anesthetics
Yes/No Amoxicillin
Yes/No Penicillin
Yes/No Sulfa Drugs
Yes/No Tetracycline
Yes/No Codeine
Yes/No Aspirin
Yes/No Iodine
Yes/No Latex
Yes/No Metabisulfites
Yes/No Narcotics ____
(controlled/prescribed by MD)
Yes/No Barbiturates or Sedatives
Yes/No Flavors, Dyes, Chemicals
Yes/No Food
Yes/No OTHER
_____
_____

MEDICAL HISTORY

Yes/No Acid Reflux/GERD
Yes/No A.I.D.S./H.I.V.
Yes/No Allergies (Seasonal)
Yes/No Alzheimer's/Dementia
Yes/No Anorexia **OR** Bulimia
Yes/No Arthritis **OR** Rheumatism
Yes/No Artificial Joint(s) ___Year/_____
Yes/No Asthma
Yes/No Autism
Yes/No Blood Pressure (Low/High/Medicated)
Yes/No Blood Transfusion __ Year
Yes/No Bruises Easily
Yes/No Cancer (Type) _____/ __Year
Yes/No Celiac Disease
Yes/No Chemotherapy
Yes/No Chest Pain
Yes/No Chronic Cough
Yes/No Cold Sores/Fever Blisters
Yes/No Congenital Heart Disease
Yes/No Contact Lenses / Glasses
Yes/No Cortisone Medicine
Yes/No Diabetes (Type___)
Yes/No Dental Implants – Titanium
Yes/No Dental phobia
Yes/No Diet (Special/Restricted)
Yes/No Emphysema
Yes/No Fainting **AND/OR** Dizzy Spells
Yes/No Glaucoma
Yes/No Hay Fever
Yes/No Headaches/Migraines **(circle one or both)**
Yes/No Hearing Impaired/Loss
Yes/No Heart Attack ____ Year
Yes/No Heart Surgery _____/ __Year
Yes/No Heart Condition / Heart Disease ***(circle which)***
Yes/No Heart Murmur
Yes/No Heart Pacemaker/Stints/Artificial Valve **(circle)**
Yes/No Hemophilia
Yes/No Hepatitis ___ (Type)
Yes/No HPV _____(when?)
Yes/No Kidney Disease
Yes/No Latex Allergy **OR** Sensitivity
Yes/No Learning Disability
Yes/No Light/Photo Sensitivity
Yes/No Liver Disease
Yes/No Lyme Disease
Yes/No Meningitis
Yes/No Mitral Valve Prolapse
Yes/No MRSA _____Area of body/ _____Year
Yes/No Nervous/Anxious
Yes/No Neurological Disorder **(MS/Parkinson's/OTHER)**
Yes/No Nursing (currently)
Yes/No Osteoporosis
Yes/No Osteonecrosis
Yes/No Pregnant ____ months
Yes/No Psychiatric/Physiological Disorder
Yes/No Radiation Therapy (Area of body? _____)
Yes/No Rheumatic Fever
Yes/No Sickle Cell Anemia
Yes/No Sinus Trouble
Yes/No Stroke
Yes/No Swollen Ankles
Yes/No Thyroid Condition/Thyroid Nodules/Goiter
Yes/No Tobacco Use **(list type: _____)**
Vape/Marijuana/CBD/THC Use **(circle)**
Yes/No Tuberculosis
Yes/No Tumors
Yes/No Ulcers
Yes/No STD's/HPV/Venereal Disease **(circle)**
Yes/No Whooping Cough
Yes/No Yellow Jaundice

***CONTINUED ON BACK ---------->**

HAS A MEDICAL DOCTOR INSTRUCTED YOU THAT YOU NEED TO BE PRE-MEDICATED PRIOR TO DENTAL VISITS? YES/ NO

*IF YES, HAVE YOU TAKEN YOUR PRE-MED TODAY? ____

HAVE YOU BEEN HOSPITALIZED (KEPT OVERNIGHT) IN THE LAST TWO YEARS? YES /NO IF YES, EXPLAIN:

_____

_____

HAVE YOU HAD ANY SURGICAL PROCEDURES IN THE LAST TWO YEARS? YES/NO

IF YES, EXPLAIN:

_____

_____

PLEASE WRITE ANY/ALL OTHER MEDICAL CONDITIONS NOT LISTED ON FRONT PAGE:

_____

_____

Primary Physician's Name: _____ Phone: _____

When was your last visit to your Primary Physician? _____ What for? _____

List all medications with dosages, ***including vitamins and supplements***, which you are taking:

_____

_____

_____

_____

_____

_____

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the above questions to the best of my knowledge. I will notify the doctor/hygienist of ANY change in my health or medication. I am aware that this office participates in the VA Prescription Monitoring Program and may access my prescription record if needed.

Signature: _____ Date:_____

!!STOP HERE STOP HERE STOP HERE STOP HERE!!

Future visits in the same year, we will have you review this form.

I HAVE REVIEWED MY MEDICAL HISTORY ABOVE. I HAVE NOTED ANY CHANGES ON THE LINES BELOW.
If no changes, please write in "NO CHANGES".

MEDICAL HISTORY CHANGES	Patient Initials	DATE	STAFF

* This page front only *

Examiner _____
Date _____

OCCLUSAL SCREENING

Name _____ Male ❑ Female ❑ Age _____

Address _____

City/State/Zip _____ Telephone _____

If No Please ✔ Check
If Yes Please Rate 1, 2 or 3 (1 - Mild 2 - Moderate 3 - Severe)

	NO	YES	COMMENTS	Date				
1. Does it ever hurt when you chew?								
2. Does it ever hurt when you open wide or take a big bite?								
3. Does your jaw ever make noise?								
4. Do you ever have headaches?								
5. Do you ever have pain in front, in or behind the ear?								
6. Do you ever have tiredness, pulling or tightness in the head, neck or throat?								
7. Do you ever have a feeling of dryness or burning in the mouth?								
8. Do you ever have to search for a place to close your teeth?								
9. Does a tooth ever get in the way?								
10. Is a tooth ever sensitive or tender?								
			Occlusal Index Total					

COMPLETE THE QUESTIONS BELOW IF ANY YES RESPONSES ABOVE

	NO	YES	COMMENTS
1. Do you ever take anything for any of the above conditions?			
2. Have you ever had an injury or blow to the head or neck region?			
3. Have you had any recent dental treatments?			
4. Has your bite ever been changed?			
5. What do any of the above conditions stop you from doing?			

When the occlusal index totals five or more, or if one question has an index of three, complete the Objective Occlusal Examination.

* To be completed by staff *

OCCLUSAL EXAMINATION

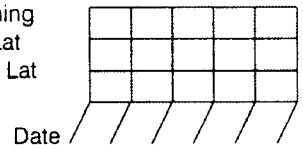
1. **INTERCUSPAL POSITION:** ❑ IP=CR ❑ IP≠CR ❑ IP=MCP ❑ IP≠MCP
C.R. ❑ Straight **I.P. SLIDE:** ❑ Right ❑ Left
CR → CO Slide _____
R.C.P. SITE: ❑ Right ❑ Left ❑ Both

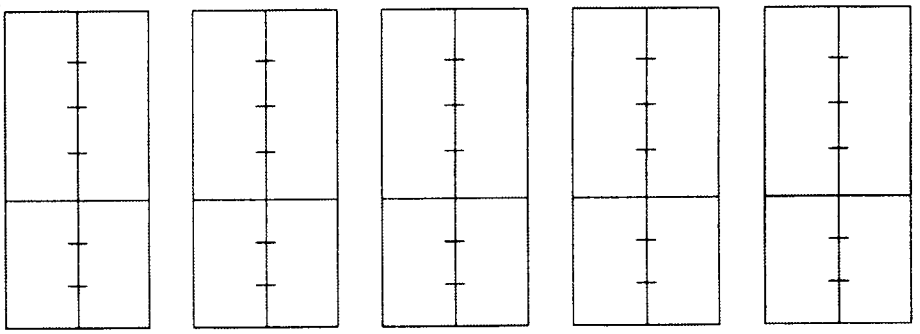
2. **TEMPOROMANDIBULAR SOUNDS:**

RIGHT	LEFT		RT	LF	RT	LF
❑	❑	None	❑	❑	❑	❑
❑	❑	Intermediate	❑	❑	❑	❑
❑	❑	Terminal	❑	❑	❑	❑
❑	❑	Continuous				

Date

3. **JAW OPENING - CLOSING PATTERN**
___mm Maximum Opening
___mm Maximum Left Lat
___mm Maximum Right Lat
❑ Painful



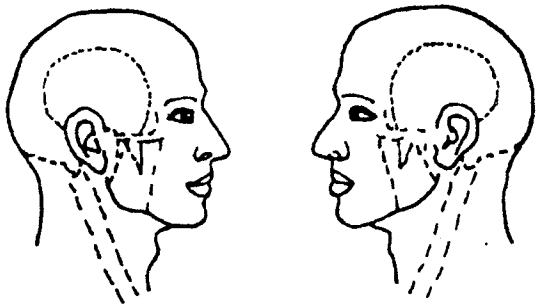


4. **RELATIONSHIP OF ANTERIOR TEETH IN I.P.:**
❑ Tooth Contact ❑ Gingival 1/3 ❑ Middle 1/3 ❑ Incisal 1/3
❑ Tissue Contact ❑ Open ❑ X-bite

5. **RELATIONSHIP OF POSTERIOR TEETH IN I.P.:**
Left Side ❑ Class I ❑ Class II ❑ Class III ❑ X-bite ❑ No Contact
Right Side ❑ Class I ❑ Class II ❑ Class III ❑ X-bite ❑ No Contact

6. **JAW MANIPULATION**

Easy	Difficult	
❑	❑	Hinge
❑	❑	Right Lateral
❑	❑	Left Lateral



7. **FACIAL PAIN AND PROVOCATION TEST:**

	i.e. Bruxofacets		Mobile Teeth		(7)
R	8 7 6 5 4 3 2 1	|	1 2 3 4 5 6 7 8	L	
	8 7 6 5 4 3 2 1	|	1 2 3 4 5 6 7 8		

PROVOCATION RESPONSE ❑ None ❑ Positive

8. **ORAL - FACIAL PALPATION:**

			RIGHT	LEFT
		Date		
1)	TMJ capsule	lateral		
		posterior		
2)	Masseter	deep		
		superior		
3)	Temporalis	anterior		
		posterior		
4)	Vertex			
5)	Neck	nape		
		base		
6)	Sternocleidomastoid	origin		
		body		
		insertion		
7)	Medial Pterygoid			
8)	Posterior digastric			
9)	Temporalis Tendon			
10)	Lateral Pterygoid			

9. **NOXIOUS ORAL HABITS:**
❑ Deviate swallow ❑ Cheek or lip habit ❑ Nail Biter ❑ Other

10. **POSTURE**
Head _____
Shoulders _____
Pelvis _____
Leg _____

11. **DENTO-CRANIAL RESTRICTIONS**
1. _____
2. _____
3. _____
4. _____

CRAIG A. ZUNKA, D.D.S.
General, Holistic and Cosmetic Dentistry
www.craigzunkadds.com

Thank you for choosing us as your dental healthcare provider. The primary goal of our dental practice is to provide the highest quality care in the most gentle, holistic, and efficient manner. Below outlines our office policies and financial agreement. This information is to be read in its entirety by the patient or the responsible party. Please let us know if you have any questions. We appreciate your trust in our team.

General: *We are not a participating provider with any insurance companies*. We are not a Medicare or Medicaid provider. Your signature on this form indicates you have been notified of this information according to Medicare and Federal regulations.

Payments: Payment in full is due at time of service. We gladly accept the following methods of payment:

- Cash/Check
- Visa, Mastercard, Discover, American Express
- Care Credit – offering a 6 month No Interest option and extended payment plans with interest.
    - Applications are not processed in office, please visit www.carecredit.com to apply and obtain an account number prior to your scheduled appointment.

Returned Checks: A $50.00 fee will be applied to your account for any check returned by your bank for any reason.

Cancelations/Broken Appointments: Your dental appointments are scheduled carefully with time, materials and dental equipment reserved specifically for your care. We understand that unforeseen circumstances may arise, which may result in a need to cancel or reschedule. We request a 48-hour advance notice for canceling or rescheduling your appointment. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty and time that could be offered to another patient is subsequently unproductive. A $75 charge may be assessed for multiple missed/broken or short notice cancelations. Multiple broken appointments may result in dismissal from our practice.

Deposits: When necessary we do require a deposit in the amount of 20% of the total appointment cost to reserve specific appointment times or for appointment of 3 or more hours. This deposit will be applied to your visit. Should you cancel less than 48 hours prior to or no-show you forfeit the deposit.

Insurance: We do not participate with any insurance companies—we are considered an "out-of-network provider". As a courtesy to you, we will generate an insurance form at check out for each visit. You may submit this completed form to your insurance company for reimbursement based on the coverage of your policy. To provide this form, you must bring your current insurance card to your visit so that we may gather the information needed to complete the form. It is YOUR responsibility to update this information with us if your coverage changes.

Please remember that your insurance policy is a contract between you and your insurance company. Some or perhaps all the services provided by our office may or may not be covered by your policy. If you have questions or concerns about coverages or limitations on your policy, please contact your benefits provider (if through an employer) or your insurance company directly by dialing the member services number on the back of your insurance card.

107 W. 4th Street
Front Royal, Virginia 22630
(540)-635-3610

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www.craigzunkadds.com

Minor children: All Minor children must be accompanied by a parent or legal guardian for treatment. The parent or legal guardian presenting with the child will be responsible for full payment at the time of service.

Communications: We may contact you via telephone, text and/or email. Our office utilizes an automated text and email system for appointment reminders. A reminder will be sent 30 days prior to and again 3-4 days prior to your appointment. At times we may need to leave a message or send an email regarding your appointments, test results, etc. By signing below, you consent to us calling, texting, email and leaving messages. If you would prefer that we NOT leave a voicemail, please notify the front desk team member.

_____ _____

PRINTED Patient Name Date

_____

Patient's Signature or Parent/Legal Guardian, if minor

107 W. 4th Street
Front Royal, Virginia 22630
(540) 635-3610

CRAIG A. ZUNKA, D.D.S., F.A.G.D., F.A.S.C.D.

Acknowledgment of Receipt of Privacy Notice

By signing below, I acknowledge that I have received Craig A. Zunka, D.D.S.'s Notice of Privacy Practices.

_____ _____

Signature (Patient or Authorized Representative) Date:

_____

Printed (Patient or Authorized Representative)

Please provide name or names for any friends, family, or other persons we may release Medical/Dental information to.

Name _____

Name _____

Name _____

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the data changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Sandy Beach. Information on contacting her can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions.

Disclosure: We may disclose and/or share your healthcare information with our health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member of anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgement to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Service: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.