SpalloneFamilyDentistry

Account #

Patient's Name ________________________ ______________________ ____
Last First Initial

Date _______________ Date of Birth _______________ Male Female

Patient's Name __________________________________

How do you wish to be addressed __________________

Single Married Divorced Widowed

Residence-Street ________________________________

City ________________ State ________ Zip ___________

Business Address ________________________________

Telephone: Res. _________________________________

Fax: _________________ Cell Phone _______________

eMail ____

Patient Employed By ______________________________

Present Position _________________________________

How Long Held ___________________________________

Who is Responsible for this account ________________

Drivers License No. ______________________________

Method of Payment: Insurance Cash Credit Card

Purpose of Call __________________________________

Other Family Members in this Practice ______________

____

Whom may we thank for the referral ________________

Patient Social Security No. _______________________

Spouse Social Security No. _______________________

Someone to notify in case of emergency not living with you ____

New Patient Registration

Dental Insurance 1st Coverage

Employee Name ________________________ Date of Birth ______________

Employer Name _________________________________ Yrs. _____________

Name of Insurance Co. ____

Address ____

____

Telephone ____

Program or Policy # ____

Social Security No. ____

Union local or Group ____

Dental Insurance 2nd Coverage

Employee Name ________________________ Date of Birth ______________

Employer Name _________________________________ Yrs. _____________

Name of Insurance Co. ____

Address ____

____

Telephone ____

Program or Policy # ____

Social Security No. ____

Union local or Group ____

RELEASE:
I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand my dental care insurance carrier pr payor of my dental benefits may pay less than the actual bill for service. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my Dental care payor.

I attest to the accuracy of the information on this page.
PATIENTS OR GUARDIANS SIGNATURE

____

DATE ____

SpalloneFamilyDentistry

Account #

Patient's Name ________________________ ___________________________ _____
Last First Initial

COMMENTS

1. Purpose of initial visit ____
____
2. Are you aware of a problem? ____
____
3. How long since your last dental visit? ____
4. What was done at that time?____
____
5. Previous dentist's name ____
Address: ____________________________________Tel: ___________________________________
6. When was the last time your teeth were cleaned? ____

IF PRINTING FORM PLEASE CIRCLE "Y" FOR YES AND "N" FOR NO, IF DIGITALLY SELECTING ITEMS PLEASE SELECT YES OR NO FROM THE DROP DOWN MENUS ON EACH LINE. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE OR SELECT "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular dental visits? ……………………………………………………………………….…
How often?____
8. Were dental x-rays taken? ………………………………………………………………………………….
9. Have you lost any teeth or have any teeth been removed? ………….…………………..……………………..
Why?____
10. Have they been replaced? …………………………………………………………………….……………
11. How have they been replaced?
    a. Fixed bridge____ Age _________________
    b. Removable bridge ____________________________________ Age ________________
    c. Denture____ Age ________________
12. Are you unhappy with the replacement? ……………………………………………………….…………..
13. If yes, explain ____
14. Have you ever had any problems or complications with previous dental treatment? ....
If yes, explain ____
15. Do you clench or grind your teeth? ……………………………………….…………………………….
16. Does your jaw click or pop? ……………………….………………………………………………….
17. Have you experienced any pain or soreness in the muscles of your face or around your ear? ……………………………………………………………….……………
18. Do you have frequent headaches, neck aches, or shoulder aches? ………………...………………….
19. Does food get caught in your teeth? ……………………………….……………………………………...
20. Are any of your teeth sensitive to: Hot? Cold? Sweets? Pressure?
21. Do your gums bleed or hurt? ………………………………………………………………………………….
When? ____
22. How often do you brush your teeth? ___________________ When? ___________________________
23. Do you use dental floss? ……………………………………………………………………………………
How often? ____
24. Are any of your teeth loose, tipped, shifted or chipped? ………………………………………………..
25. Are you unhappy with the appearance of your teeth? ……………………………………………………..
26. How do you feel about your teeth in general? ____
27. Do you feel your breath is offensive at times? …………………………………………………………
28. Have you ever had gum treatment or surgery? ………………………………………………………..
What? ____
Where? ____
When? ____
29. Have you had any orthodontic work? ____
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you Strongly dislike? ____
31. Do you have any questions or concerns? ……………………………………………………….
I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE
PATIENT'S/GUARDIAN'S SIGNATURE___________________________________ DATE ____________
DENTISTS SIGNATURE____ DATE ____________

DENTAL HISTORY

SpalloneFamilyDentistry

Account #

Patient's Name ________________________ ____________________________ ________
Last First Initial

CIRCLE/SELECT THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE/SELECT "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name ____
   Address ____
   ____
2. Are you under a physicians care? ……………………………………………………………………………
   Since when? ________________________________ Why? __________________________________
3. When was your last complete physical exam? ____
4. Are you taking any medications or substances? …………………………………………………………
   (If yes, please list medication in comments section or on the side of this form)
5. Do you routinely take health related substances? ……………………………………………………..
6. Are you allergic to any medications or substances? ……………………………………………………
7. Do you have any other allergies? ………………………………………………………………………………
8. Do you have any problems with penicillin, antibiotics, anesthetics? or other medications? ……………………………………………………………………
9. Are you sensitive to any metals or latex? ………………………………………………………………..
10. Are you pregnant or suspect you may be? ……………………………………………………………
11. Do you use any birth control medications? …………………………………………………………
12. Have you ever been treated for or been told you might have heart disease? ………………………………
13. Do you have a pacemaker or an artificial heart valve implant? …………………………………………..
14. Have you ever had rheumatic fever? ………………………………………………………………………..
15. Are you aware of any heart murmurs? ……………………………………………………………………
16. Do you have high or low blood pressure? ……………………………………………………………..
17. Have you ever had a serious illness or major surgery? …………………………………………………
    If so, explain ____
18. Have you ever had a radiation treatment, chemo treatment for tumor, Growth or other condition? ……………………………………………………………………
19. Do you have inflammatory diseases, such as arthritis or rheumatism? ………………………………………
20. Do you have any artificial joints/prosthesis? ……………………………………………………………
21. Do you have any blood disorders, such as anemia, leukemia, etc? ……………………………………..
22. Have you ever bled excessively after being cut or injured? ……………………………………………….
23. Do you have any stomach problems? ………………………………………………………………………
24. Do you have any kidney problems? ………………………………………………………………………..
25. Do you have and liver problems? ………………………………………………………………………….
26. Are you diabetic? …………………………………………………………………………………………….
27. Do you have asthma? ………………………………………………………………………………………..
28. Do you have epilepsy or seizure disorders? ……………………………………………………………..
29. Do you or have you had venereal disease? ……………………………………………………………...
30. Have you tested HIV positive for hepatitis? ………………………………………………………………
31. Do you have AIDS? …………………………………………………………………………………………..
32. Do you or have you had T.B.? ……………………………………………………………………………...
33. Do you smoke, chew, use snuff or any other forms of tobacco? ………………………………………
34. Do you consume alcoholic beverages? ………………………………………………………………….
35. Do you habitually use controlled substances? ……………………………………………………………
36. Have you had psychiatric treatment? ………………………………………………………………………
37. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? …………………………………………
38. Do you have any disease condition, or problem not listed? If so, explain ________________________
    ____
39. Is there anything else we should know about your health that we have not covered in this form? ____
40. Would you like to speak to the doctor privately about any problem? ……………………………………..

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE________________________________ DATE ____________

DENTISTS SIGNATURE____ DATE ____________

COMMENTS

Allergies:_______________
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Medication:_____________
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Hospitalizations:__________
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HIV/Aids___________Yes

MEDICAL HISTORY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ________________________________ **Email:** ______________________________

Patient #: _________________________________ **Social Security #:** __________________________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form you will consent to our disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, patient activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notices of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: ____

Telephone: ________________________________ **Fax:** ___________________________________

E-mail: ____

Address ____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your Revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,___________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, Payment activities and health care operation.

Signature:____ **Date:** ______________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT:
Include completed Consent in the patient's chart.