Patient Information

Patient Name: _____ Date_____
Last, First MI (Preferred Name)

☐ Male ☐ Female E-MAIL Address: _____

Social Security #: _____ Birth Date: _____ Age: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell) _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact:_____ Phone#:_____

Whom May we thank for referring you to our practice?_____

Health Information

Date of Last Dental Visit:_____ Reason for this visit: _____

Please check all that apply:

☐ AIDS/HIV

Allergies

- ☐ Nickel
- ☐ Codeine
- ☐ Penicillin
- ☐ Latex
- ☐ Ibuprofen
- ☐ Aspirin
- ☐ Sulfa
- ☐ Anesthetic

Type:_____

☐ Anemia
☐ Alcohol/Drug Dependency
☐ Arthritis

☐ Artificial Joints
☐ Asthma
☐ Bleeding Gums
☐ Blood Disease
☐ Cancer
☐ Currently Under Treatment
☐ Diabetes
☐ Dizziness
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths/Tumors
☐ Hay Fever
☐ Head/Neck Injuries

☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis A, B or C
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Disorders
☐ Nervous Disorders
☐ Osteoporosis Medications
☐ Pacemaker
☐ **Currently** Pregnant
Due date:_____
☐ Respiratory Problems

☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Smoker
how many per day?_____
☐ Stomach or duodenal Ulcers
☐ Stroke-Date _____
☐ Thyroid
☐ Tuberculosis
☐ Viral Infections/Cold Sores

OTHER:_____
☐ _____
☐ _____
☐ _____
☐ _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____

Office Use Only

Date: _____	Date: _____	Date: _____	Date: _____
Health Changes:	Health Changes:	Health Changes:	Health Changes:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Current Medications:	Current Medications:	Current Medications:	Current Medications:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Initials _____	Initials _____	Initials _____	Initials _____

Parent, Spouse or Responsible Party Information

Please complete this section if this form is for a minor child, a guardianship and/or caregiver responsible for this patient.
Name: _____ Relationship to Patient: _____

☐ Male ☐ Female Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell) _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

I understand that any information regarding treatment, payment and operations of my account will be disclosed to any and all persons listed below, unless I specifically request to be placed on a separate account. If I agree, should at any time I would like to change my status I may do so. I Agree _____initial I DO NOT Agree _____ Initial

Primary

Insurance Plan Name:_____Phone #: _____

Claims Mailing Address:_____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____ Phone #: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Insurance Plan Name:_____Phone #: _____

Claims Mailing Address:_____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____ Phone #: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services

Appointment Guidelines- I understand that Dr. Pisciotta's Office requires 48 hours notice (2 business days) in order to reschedule any appointments; failure to give sufficient notice will result in a cancellation fee of $50 per hour scheduled. _____**initial**

Payment- I agree to pay at the time services are rendered and understand that the forms of payment are Cash, Check, Visa, Master Card & Discover. In the case that my insurance company does not pay the estimated amount I understand that Dr. Pisciotta's Office will send me a statement of my balance. I agree to pay all balances billed to me by the due date and if I need to make financial arrangements I will contact the office prior to my due date. I also understand the I am subject to a 12% APR finance charge on any balances not paid with a minimum charge of $2.00 per month Failing to comply by the due date could result in my account being forward to a third party for collections which could damage my credit. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. _____**initial**

Insurance- I understand that all dental services furnished are charged directly to me, the patient or guardian and that I am personally responsible for payment of all dental services. Dr. Pisciotta's Office will help prepare the insurance forms or assist in making collections from insurance companies and will credit any such collections to my account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I also acknowledge that it is my responsibility to know and understand my insurance benefits and that the estimated copayments given are just estimates, should I require a definite answer I will contact my insurance company directly. _____**initial**

HIPAA-I understand that this office complies with the Health Insurance Portability and Accountability Act (HIPAA). I have read the full explanation of the policy to include how my information is protected, as well as information on how to file a complaint. I understand that this policy is also posted in the waiting room, as well as at the front desk. Should I require more information or a copy of the policy, I may obtain it from any staff member. I grant permission for Dr. Pisciotta's office to contact me on my home, cell or personal work number to discuss matters related to my care and I give permission for a message to be left if I am not available. I also grant permission for mailings to be sent to my house or billing address provided. . _____**initial**

Treatment-I understand that any treatment diagnosed will be explained to me and I will be given the choice to complete the recommended treatment. I will not hold Dr. Pisciotta's Office responsible for any adverse conditions that may result from not completing the recommended treatment. Furthermore I understand that regular maintenance is always recommended should I fail to keep up with the regular maintenance schedule set forth the restorative treatment i.e. fillings, crowns etc. could fail prematurely. _____**initial**

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____ _____
Signature of patient, parent or guardian Date Relationship to Patient

_____ _____ _____
Signature of guarantor of payment/responsible party Date Relationship to Patient