ANTHONY DELUCIA, D.D.S., P.A.
COSMETIC & GENERAL DENTISTRY

Patient Information

Patient name :_____ Date :_____
Last First MI (Preferred Name)
Email_____ Gender:_____ Family Status:_____
Social Security #: _____ Birth Date: _____
Phone (Home):_____ (Work):_____ EXT:____ Cell Phone:_____
Address:_____
Street Apartment #
_____
City State Zip Code

D.License_____

Health Information

Date of last Medical Visit: _____ Reason for Visit:_____
Are you in good health now? __Yes __ No
Are you now, or have you been under the care of a physician in the last 12 months? __Yes __ No
If so what condition is being treated? _____
Physician's Name_____ Address_____ Phone_____
Have you ever been hospitalized or had a serious illness? __Yes __No
If yes, explain_____
Have you had excessive bleeding requiring special treatment? __Yes __No
Do you take Aspirin daily? __Yes __No
Do you take Ibuprofen (Advil or Motrin) daily? __Yes __ No
Are you taking or have you taken any Bisphosphonate medications (Iridia, Zometa, Fosamax0, etc. to your knowledge? __Yes __No
Are you currently taking any medication prescribed by a doctor? __Yes __ No
Are you currently taking any OTC (over the counter) medications? __Yes __No
Are you currently taking any medications self prescribed? __Yes __No
Are you taking any holistic, homeopathic or alternative supplements (herbs, vitamins, minerals)? __Yes __No
Please list name of all medications, herbs, vitamins, their purpose, and dosage below.

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Have you ever had any of the following? Please circle those that apply:

	Fainting	Pacemaker
AIDS	Glaucoma	Current Pregnant
HIV	Growths	Due date:_____
Allergies	Hay Fever	Radiation Treatment
Anemia	Head Injuries	Respiratory Problems
Arthritis	Heart Disease	Rhuematic Fever
Artificial Joints	Heart Murmur	Rhuematism
Asthma	Hepatitis	Sinus Problems
Blood Disease	High Blood Pressure	Stomach Problems
Cancer	Jaundice	Stroke
Diabetes	Kidney Disease	Tuberculosis
Dizziness	Liver Disease	Tumors
Epilepsy	Mental Disorders	Ulcers
Excessive Bleeding	Nervous Disorders	*CONTINUED....*

Venereal Disease	Erythromycin Allergy	Bacterial Endocarditis
Codeine Allergy	Latex Allergy	Other: _____
Penicillin Allergy	Heart Valve Replacements	_____
Tetracycline Allergy	Stents	_____

Date of last Dental visit?_____ Reason for visit? _____

- Have you ever had any complications following dental treatment? ___ Yes ___ No
  If yes, please explain_____
- Does Dental treatment make you nervous or anxious? ___ Yes ___ No.
  If yes, what level would you rate: __Slight __Moderate __Severe
- Do you have any health problems that need further clarification? ____ Yes ____ No
  If yes, please explain_____

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.

_____ Date:_____

Signature of patient , parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Please check.
__ Another patient, friend __ Another patient, relative __ Dental Office __ Yellow Pages
__ Newspaper __ School __ Work __ Other
Name of person or office referring you to our practice:_____

Spouse or Responsible Party Information

The following is for: __ the patient's spouse __ the person responsible for payment
Name:_____

_____

___ Male ___ Female ___ Married ___ Single ___ Child ___ Other

Social Security#: _____ Birth Date:_____

Phone(Home):_____ (Work):_____ Ext_____ Best time to call_____

Address:_____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: __ the patient's spouse __ the person responsible for payment
Employer name:_____ Occupation_____

Address:_____

Street City State Zip Code Phone

Insurance Information

Primary

Name of insured: _____ is insured a patient? __Yes __No
Last First MI

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

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: __Self __Spouse __Child __Other

Insurance Plan name and Address: _____

_____

Secondary

Name of insured: _____ is insured a patient? __Yes __No
Last First MI

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

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: __Self __Spouse __Child __Other

Insurance Plan name and Address: _____

_____

ANTHONY DELUCIA, D.D.S., P.A.
COSMETIC & GENERAL DENTISTRY

PATIENT CONSENT FORM

Patient Name_____
Last First Middle

I hereby authorize Anthony DeLucia D.D.S., P.A. and whomever he may designate as his assistants, to perform upon me the following operation and/or procedures:

EXAMS, X-RAYS, FILLINGS IF NEEDED, CLEANING WHEN NEEDED, EXTRACTIONS IF NEEDED, ROOT CANAL IF NEEDED, AND ANY PROCEDURE THAT IS NEEDED ORALLY.

And if any unforeseen condition arises in the course of these designated operations and/or procedures calling in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize him to do whatever he deems advisable.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available, the known material risks of the treatment to be used and the consequences if this treatment were withheld.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include postoperative bleeding, swelling, or bruising; discomfort, stiff jaw, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbance (e.g. numbness in the mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response (e.g. allergic reactions) cardiac arrest, and aspiration and phrombophhlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves, which may cause by injections of any medications or drugs.

A more complete explanation of all complications of surgery and anesthesia is available to me upon my request from the Doctor.

I realize that in spite of the possible complications, my contemplated surgery/ treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.

_____ Date
Signature of Patient

_____ Date
Signature of Parent or Guardian

_____ Date
Signature of Witness

772.287.7077 • FAX 772.220.4702 • 731 COLORADO AVE., STUART, FLORIDA 34994 www.drdelucia.com • email:smile@drdelucia.com

ANTHONY DELUCIA, D.D.S., P.A.
COSMETIC & GENERAL DENTISTRY

INSURANCE POLICY

Our practice understands that our patients rely on their dental insurance to help defray the cost of their dental services. We agree to investigate what the insurance can do to assist them in paying for services and to explain the limits of their policy to them. We agree to use the current ADA codes, accurately reports dates of service and keep abreast of any changes to the plan . We will be efficient in our processing of claims. We understand that our follow up process is limited to rebilling insurance companies. We will be efficient in our processing steps and to turn any unpaid claims over to the patient for payment in 60 days.

FINANCIAL POLICY

In order to provide excellent service, our practice must also be a successful business. This means we must charge fair fees and collect them. I understand that my dental insurance may pay less then their estimate and that I am responsible for any unpaid portion.

I am aware that I am responsible for any fee involved in collecting a past due account. This can include and not be limited to: court fees, attorney fees, and or fees from collection companies.

You can help us keep our cost down by paying for services in the following ways:

1. Cash or credit cards including Visa, Mastercard, Discover, and American Express
2. Monthly payments with an approved Care Credit or Capital One account

Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
And
Office Policies

****You May Refuse to Sign This Acknowledgement****

- ✓ I have received a copy of this office's **Notice of Privacy Practices.**
- ✓ I give my permission to send a recall appointment card to my home and office.
- ✓ I give my permission to send billing information to my home and office.
- ✓ I give permission to leave appointment, billing or dental information on my answering machine/ voice mail/email.
- ✓ I give my permission to share appointment, billing or dental information with the person named here

_____

(Named person to share Information with.)

- ✓ So that the Dentist, Staff, and other Patients will not be inconvenienced by those who fail to keep their scheduled appointments, this office has adopted a policy of charging a fee of $25.00 to those patients who fail to give sufficient notice (24 hours) for broken appointments.
- ✓ Patients who repeatedly break appointments will be requested to seek dental treatment at another office.
- ✓ We reserve the right to change our privacy practices as described in our Notice of Privacy Practices.

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 operations.
I understand and agree to the Above:

_____

{Signature} {Date}

_____

Personal Representative's Name Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify):_____

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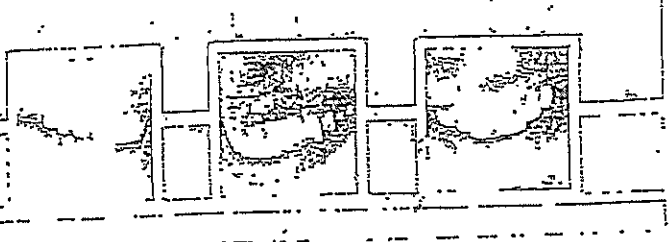

Consent for Internet Communications

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature of patient, parent, or guardian:

Date: _____

Signature: _____

Relationship to Patient:

_____

Response Date: _____