PATIENT INFORMATION

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

Gender: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced SSN: _____

Birth Date: _____ Phone (Cell): _____ (Home): _____ (Work): _____EXT:_____

Address:_____

_____

Employer name: _____ Occupation: _____ ☐Retired

Work Address:_____

E-Mail: _____ Driver's License Number: _____

Emergency Contact: _____ Phone: _____

HEALTH INFORMATION

DENTAL HISTORY

Reason for today's visit: _____ Length of time of symptoms: _____

Date of last dental visit: _____ Former dentist: _____ Date of last dental x-rays: _____

Please check if you have/had:	Yes	No
Bad Breath	☐	
Blisters on lips or mouth	☐	
Burning sensation on tongue	☐	
Smoke (e.g. cigar, cigarettes)	☐	
Smokeless tobacco	☐	
Dry mouth	☐	
Food collection between teeth	☐	
Clench or grind teeth	☐	
Growths or sore spots in mouth	☐	
Gums swollen, tender or bleeding	☐	
Lip or cheek bleeding	☐	
Head, neck, jaw pain, or aches	☐	
Loose teeth or broken fillings	☐	
Mouth breathing	☐	

	Yes	No
Orthodontic treatment	☐	
Nitrous oxide	☐	
Periodontal treatment	☐	
Sensitivity to pressure or irritants:	☐	
Cold	☐	
Heat	☐	
Sweets	☐	
Radiation to head and/or neck	☐	
Wear a night guard	☐	
How often do you floss? _____	☐	
How often do you brush? _____	☐	

Have you ever had an allergic reaction to Novocaine, ☐ local anesthetic, or ☐ nitrous oxide?
If yes, please explain:
_____
_____
_____

Have you ever had trouble from previous dental care? ☐Yes ☐No
If yes, please explain:
_____
_____
_____
_____

MEDICAL HISTORY

Physician's Name: _____ Date of last visit: _____

Reason for visit: _____

Physician's Address: _____ Phone: _____

Have you ever been hospitalized or had a serious illness? ☐Yes ☐No

If yes, explain: _____

Have you ever had a blood transfusion? ☐Yes ☑No If yes, approximate dates: _____

(Women) Are you pregnant? ☐Yes ☑No Due date: _____ Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Please check if you have/had:	Yes	No		Yes	No		Yes	No
AIDS			Heart disease			Tuberculosis		
Allergies, hay fever, sinusitis			HIV			Tumor or growth on head/neck		
Anemia			High blood pressure			Ulcer		
Arthritis, Rheumatism			Hip or knee replacement			Venereal disease		
Artificial heart valves/stents						Weight loss, unexplained		
Artificial joints			Jaundice			Do you wear contact lenses?		
Asthma			Kidney disease			Do you consume alcoholic beverages?		
Bacterial Endocarditis			Liver disease					
Bleeding abnormally with operations or surgery			Low blood pressure			Are you allergic to Latex?		
			Mental disorders			Allergic to Penicillin?		
Blood disease, clotting disorders			Mitral valve prolapse			Allergic to Aspirin?		
			Nervous disorders			Allergic to Erythromycin?		
Bruise easily			Osteoporosis			Allergic to Tetracycline?		
Cancer			Pacemaker			Allergic to Codeine?		
Chemical dependency			Pins, plates, rods, or screws			Allergic to Advil, Motrin, or Ibuprofen?		
Chemotherapy								
Circulatory problems			Radiation treatments			Are you taking or have you taken any Bisphosphonate medications (Iridia, Zomete, Fosamax, etc.)?		
Cortisone treatments			Respiratory disease					
Cough, persistent or bloody			Rheumatic fever					
Diabetes			Scarlet fever					
Dizziness			Shortness of breathe			List any medications, herbs, supplements, and vitamins that you are taking:		
Emphysema			Sinus trouble					
Epilepsy			Sickle cell anemia					
Excessive bleeding			Skin rash					
Fainting			Slow healing wounds					
Glaucoma			Stroke					
Growths			Swelling of feet or ankles					
Head injury								
Headaches			Thyroid problems					
Heart murmur			Tonsillitis					

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

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent or Guardian Date

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Please check.

☐Patient, ☐Friend, ☐Co-worker
Name: _____
☐Doctor's office. Doctor: _____
☐Yellow Pages book
☐Yellow Pages online
☐MoneySaver
☐Insurance plan
☐Internet search.
Search engine (e.g. Google, Bing): _____
☐Website
☐Other: _____

FINANCIALLY RESPONSIBLE PARTY INFORMATION

Is the patient financially responsible? ☐ Yes ☐No. If no, please fill out the form below.

Name: _____ Relationship to Patient: _____
Last First MI

Gender: ☐Male ☐Female Marital Status: ☐Married ☐Single Social Security Number: _____

Birth Date: _____ Phone (Cell): _____ (Home): _____ (Work): _____EXT:_____

Address:_____

_____

Employer name: _____ Occupation: _____ ☐Retired

Work Address:_____

E-Mail: _____ Driver's License Number: _____

INSURANCE INFORMATION

PRIMARY (PLEASE PROVIDE INSURANCE CARD FOR US TO COPY.)

Insurance Co.: _____ Insurance Co. Phone: _____

Policy Holder: _____ SSN: _____ Birth Date: _____

Relationship to patient: ☐Self ☐Spouse ☐Child ☐Other_____ Is the insured a patient? ☐Yes ☐No

Insured's Address:_____

ID/Policy #: _____ Group #: _____ Group Name: _____

SECONDARY

Insurance Co.: _____ Insurance Co. Phone: _____

Policy Holder: _____ SSN: _____ Birth Date: _____

Relationship to patient: ☐Self ☐Spouse ☐Child ☐Other_____ Is the insured a patient? ☐Yes ☐No

Insured's Address:_____

ID/Policy #: _____ Group #: _____ Group Name: _____

INSURANCE POLICY

Our practice understands that our patients rely on their dental insurance to help them defray the costs 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 report dates of services 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.

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 than their estimate and 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 but 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, and Discover.
2. Monthly payments with an approved Care Credit or Capital One account.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent or Guardian Date

PATIENT CONSENT FORM

Patient Name: _____
Last First MI

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 NEEDEDM CLEANINGS 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 nerve disturbance (e.g. numbness in the mouth and lip tissues), jaw fractures, sinus exposure and swelling 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 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 the aspiration and thrombophlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves, which may be caused 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 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 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.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Guardian Date

ACKNOWLEDGEMENT OF RECIPT OF NOTICE OF PRIVACY PRACTICES AND OFFICE POLICIES

YOU MAY RESUFSE 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 ☐Office
- I give permission to send billing information to my: ☐Home ☐Office
- I give permission to leave appointment, billing or dental information on my:
  ☐Answering machine ☐Voicemail ☐E-mail
- I give my permission to share appointment, billing or dental information with the person(s) named here:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

- So that the Doctor, 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 practice 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 of Patient Date

_____ _____
Signature of Parent or Guardian Date

FOR OFFICE USE ONLY

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

☐Individual refused to sign

☐Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify): _____

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to the dental practice to upload and store confidential patient information (including account 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 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 practices 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 effort 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 Date

_____ _____

Signature of Parent or Guardian Date

SMILE EVALUATION

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

1. Do you like the way your teeth look? ☐Yes ☐No

   Explain: _____

2. Are you happy with the color of your teeth? ☐Yes ☐No

   Explain: _____

3. Would you like for your teeth to be whiter? ☐Yes ☐No

   Explain: _____

4. Would you like for your teeth to be straighter? ☐Yes ☐No

   Explain: _____

5. Do you have spaces between your teeth that you would like closed?

   ☐Yes ☐No If so, where? _____

6. Would you like your teeth to be longer? ☐Yes ☐No

   If so, which teeth? ☐Upper ☐Lower ☐Both

7. Do you like the shape of your teeth? ☐Yes ☐No

   Explain: _____

8. Do you have missing teeth that you would like to replace?

   ☐Yes ☐No Explain: _____

9. Do you have old silver fillings that you would like to replace with tooth-colored fillings?

   ☐Yes ☐No Explain: _____

10. If you could change anything about your smile, what would you change?

    _____

    _____

    _____

    _____