PATIENT MEDICAL AND DENTAL HISTORY

Patient Name: ____Today's Date: _________

Name of General Dentist:_____________________________________ How Long: ___________

Whom may we thank for referring you to our office if other than your Dentist? ________________

Physician: ____Office phone: _________________

When was the approximate date of your last physical? __________________________________

Are you under medical treatment now? Yes or No

Have you ever been hospitalized for any surgical operation or serious illness? Yes or No

If yes, please explain ____

Are you taking any medication(s) including non-prescription medicine? Yes or No

If yes please list: ____

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Do you smoke? Yes or No (If yes how much?) ___________

Do you premedicate with antibiotics for dental appointments? Yes or No

Are you taking aspirin daily? Yes or No

ARE YOU PRESENTLY TAKING OR HAVE YOU EVER TAKEN BISPHOSPHONATES e.g.-
Fosamax, Actonel, Boniva, Zometa, Aredia etc. ? YES or NO

If yes Dosage __________mg

How long have you been taking this medication? ____________

Did you take this medication in the past and stop? YES or NO If yes, how long ago? ___________

Are you allergic to or have you ever had any reactions to the following? (Please circle all that apply)

Local anesthetics (e.g. novocaine)	Iodine	Latex
Penicillin or other antibiotics	Sulfa Drugs	Food _________________
Barbiturates	Aspirin	Other_________________
Sedatives	Codeine	

WOMEN ONLY: (Circle all that apply)

Are you pregnant or think you may be pregnant? Yes or No

Are you nursing? Yes or No

Are you taking birth control pills? Yes or No

Have you had or do you currently have any of the following? (Circle all that apply)

Abnormal bleeding	Drug Addiction	Low Blood Pressure
AIDS or HIV infection	Emphysema	Mitral Valve Prolapse
Anemia	Epilepsy/Seizures	Organ Transplant
Angina (chest pains)	Glaucoma	Psychiatric Treatment
Arthritis	Hay Fever/Allergies	Radiation Therapy
Asthma	Heart Attack	Rheumatic Fever
Bacterial Endocarditis	Heart Murmur	Scarlet Fever
Bladder Disease	Heart Valve Replacement	Sexually Transmitted Disease
Cancer	Hepatitis/Jaundice	Sinus Trouble
Cardiac Pacemaker	High Blood Pressure	Steroid Therapy
Chemotherapy/Radiation	History of Blood Transfusion	Stomach Troubles/Ulcers
Congenital Heart Disease	Joint Replacement/implant	Stroke
Convulsions	Kidney Disease	Thyroid Problem
Damaged Heart Valve	Leukemia	Tuberculosis
Diabetes-Type I or II	Liver Disease	Ulcers

What is the nature of your dental problem? ____

Please check all that apply:

___ Do your gums bleed while brushing or flossing?

___ Have you had any head, neck, or jaw injuries?

___ Do you clench or grind your teeth?

___ Have you had orthodontic therapy (braces)?

___ Have you ever had any prolonged bleeding following extractions?

___ Have you had previous periodontal or gum treatment?

___ Does your jaw click?

___ Are you experiencing pain in your joint, face, or mouth?

___ Do you have difficulty in opening or closing?

___ Have you noticed any shift in your teeth or bite?

___ Do you have any sores or lumps in your mouth?

Do you have any diseases, conditions, or problems not listed above that we should know about?

____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform Dr. Cascino or Dr. Pizzurro at the next appointment.

Signature ____Date: ________________

Patient Name: ____ Today's Date: ___________________
Address: ____
City: ____Zip Code:______________________________
Home Phone: ___________________ Work Phone: ___________________ Cell Phone: __________________
E-mail Address: ____
Date of Birth: ______________________________ Social Security Number: ___________________________
Occupation: _______________________________________
(Circle one): Minor Single Married Divorced Widowed Separated
Name of person we may contact in case of emergency: ____
Phone number: ____________________________ Relationship to patient: ____________________________

RESPONSIBLE PARTY (If different from above**)**

Name of person responsible for this account: ____
Relationship to patient: ____
Address: ____
City: ____ Zip Code: ___________________________
Home Number: _______________________________________ Date of Birth: _________________________
Social Security Number: ________________________________ Business Phone: ______________________
Occupation: ____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance:

Name of the Policy Holder: ____________________________ Is the policy holder the patient? Yes or No
Policy holders date of birth: _____________________________ID #: ______________________________
Policy holder's employer name: ______________________________________ Group #: __________________
Insurance plan name: _______________________________________ Phone number: ___________________
Insurance mailing address: ____
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Secondary Dental Insurance:

Name of the Policy Holder: _____________________________ Is the policy holder the patient? Yes or No
Policy holders date of birth: _____________________________ ID #: _______________________________
Policy holder's employer name: ______________________________________ Group #: __________________
Insurance plan name: _______________________________________ Phone number: ___________________
Insurance mailing address: ____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without pervious financial arrangements, must be paid in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from the insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of one year from the date of patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term of condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

There is a fee of $50.00 per scheduled hour for any appointments that are not given a minimum of a 48 hour cancellation notice.

I have read the above conditions of treatment and payment and agree to their content.

____

Signature of Guarantor of payment/responsible party Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Robert E. Pizzurro, DDS LTD
Susan A. Cascino, DDS
10 W Martin Avenue # 211
Naperville, IL 60540
630-355-5010

MY SIGNATURE CONFIRMS that I have been informed of my rights to privacy regarding my protected health information, under the Health Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

In addition, I consent to receiving reminders regarding my dental cleanings via postcard, and I agree to allow our staff to confirm my appointment and to remind me of necessary medications that I may need to take by leaving messages on voice mail and/or answering machines at home or work or with a family member.

Patient Name: ____ Date: ________________________

Signature: ____

Relationship to patient: _________________________________

Dependent family members also covered by this acknowledgement:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

☐ The Patient refused to sign ☐ Emergency situation ☐ Communication barriers ☐ Other