

## 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? \_\_\_\_\_

Physician: \_\_\_\_\_ Office phone: \_\_\_\_\_

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: \_\_\_\_\_

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? Yes or No

**ARE YOU PRESENTLY TAKING OR HAVE YOU EVER TAKEN BISPHOSPHONATES** e.g.-

Fosamax, Actonel, Boniva, Zometa, Aredia etc. ? Yes or No

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 mark Y for yes or N for no

- |   |   |
|---|---|
| _____ Do your gums bleed while brushing or flossing?                  | Have you ever experienced any of the following?         |
| _____ Have you had any head, neck, or jaw injuries?                   | _____ Clicking?   |
| _____ Do you clench or grind your teeth?                              | _____ Pain (joint, ear, side of face)?                  |
| _____ Have you had orthodontic therapy (braces)?                      | _____ Difficulty in opening or closing?                 |
| _____ Have you ever had any prolonged bleeding following extractions? | _____ Have you noticed any shift in your teeth or bite? |
| _____ Have you had previous periodontal or gum treatment?             | _____ 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. Pizzurro or Dr. Cascino 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

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: \_\_\_\_\_

#### **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 previous 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.

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

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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.

? YES      ? NO

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**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