SpalloneFamilyDentistry

Account #

Patient's Name _____ _____ ____
Last First Initial

Date _____ Date of Birth _____ Male ☐ Female ☐

If Child: Parent's Name _____

How do you wish to be addressed _____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐

Residence-Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____

Fax: _____ Cell Phone _____

eMail _____

Patient Parent Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ☐ Cash ☐ Credit Card ☐

Purpose of Call _____

Other Family Members in this Practice _____

_____

Whom may we thank for the referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

Dental Insurance 1st Coverage

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

_____

Telephone _____

Program or Policy # _____

Social Security No. _____

Union local or Group _____

Dental Insurance 2nd Coverage

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

_____

Telephone _____

Program or Policy # _____

Social Security No. _____

Union local or Group _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand my dental care insurance carrier pr payor of my dental benefits may pay less than the actual bill for service. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my Dental care payor.

I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIANS SIGNATURE

_____

DATE _____

New Patient Registration

SpalloneFamilyDentistry

Account #

Patient's Name _____ _____ _____
Last First Initial

Patient/Guardian Name _____

DENTAL HISTORY – CIRCLE/SELECT THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? ..... Y / N
2. If not, how long since the last visit to the dentist? ..... Y / N
3. Were any x-rays or radiographs taken when your child visited the dentist? ..... Y / N
4. Does your child eat between meals? ..... Y / N
5. Does your child eat sweets, such as candy, soda pop, chewing gum? ..... Y / N
6. When does your child brush his/her teeth? ..... Y / N
   Upon arising ☐ After eating any food ☐ Right after meals ☐ before going to bed
7. Does your child receive fluoride? ..... Y / N
   How?_____
   Community water level_____ppm Well water level_____ppm
   Fluoride drops or tables Fluoride rinse or gel
8. Have any cavities been noted in the past? ..... Y / N
9. Were any teeth (baby or permanent) removed by extraction? ..... Y / N
   Was it suggested that the space be maintained? ..... Y / N
   Was an appliance placed? ..... Y / N
10. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ..... Y / N
    If so describe_____
11. Has your child had any problem with dental treatment in the past? ..... Y / N
12. Has anyone in the family, including parents, had orthodontics? ..... Y / N
13. Has your child ever received a local anesthetic? ..... Y / N
14. Has your child ever had occlusal sealants? ..... Y / N
15. Does your child think there is anything wrong with his/her teeth? ..... Y / N

MEDICAL HISTORY

1. Does your child have any health problems? ..... Y / N
2. Is your child under care of physician? ..... Y / N
   If yes, since when and why? _____
3. Name of physician _____
4. Is your child receiving any medication? ..... Y / N
   What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs? ..... Y / N
6. Is your child allergic or sensitive to any metals or latex? ..... Y / N
7. Does your child have other allergies? ..... Y / N
8. Has your child had any serious illness? ..... Y / N
9. When_____ What _____
10. Has your child ever had surgery? ..... Y / N
11. Does your child have a heart murmur? ..... Y / N
12. Is surgery contemplated? ..... Y / N
13. Does your child experience severe or prolongated bleeding? ..... Y / N
14. Does your child have AIDS or has he/she tested HIV positive? ..... Y / N
15. Is your child subject to nervous disorders? ..... Y / N
    Fainting? ☐ Seizures? ☐ Dizziness? ☐ Behavioral/Learning ☐ Problems?
16. Does your child have frequent headaches? ..... Y / N
17. Has your child had history of: (select appropriate responses) ☐ diabetes ☐ heart trouble ☐ kidney ☐ Infection ☐ rheumatic fever ☐ epilepsy ☐ cerebral palsy ☐ liver problems ☐ congenital birth defects ☐ mental retardation ☐ eyesight problems ☐ cancer ☐ infections ☐ speech impairments ☐ hearing loss

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE_____ DATE _____

DENTISTS SIGNATURE_____ DATE _____

COMMENTS

CHILD DENTAL MEDICAL HISTORY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ **Email:** _____

Patient #: _____ **Social Security #:** _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form you will consent to our disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, patient activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notices of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ **Fax:** _____

E-mail: _____

Address _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your Revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

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 operation.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT:
Include completed Consent in the patient's chart.