Registration (Please Print)

(Date________________ Home Phone__________________________Cell Phone_______________________

Email:____

PATIENT INFORMATION

Name____SS#________________________

Last First Initial

Address____

City____________________________________State__________________Zip____________________

Sex M F Age_______Birthdate________________ Single Married Widowed Divorced Other

Patient Employed by____________________________________Occupation______________________

Business Phone___________________ Whom may we thank for referring you?______________________

In case of emergency who should be notified?___________________________Phone__________________

I will be paying today by: Check Cash Visa MasterCard AMEX Discover

PRIMARY DENTAL INSURANCE

Policy holders name______________________________ D.O.B.___________SS#____________________

Last First Initial

Policy holders address(if different from patient)____

Policyholder employed by______________________________________Occupation___________________

Business Phone______________________ Your relation to the policy holder_________________________

Insurance Company____Group #_______________________

Name of other dependants covered under this plan____

ADDITIONAL DENTAL INSURANCE

Policy holders name______________________________ D.O.B.___________SS#____________________

Policyholder employed by______________________________________Occupation___________________

Business Phone__________________ Your relation to the policy holder______________________________

Insurance Company____Group #_______________________

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1. Do your gums bleed?.. Yes No
2. When was your last FMX?____
3. Do you like your smile?... Yes No
4. Have you considered bleaching your teeth?.. Yes No
5. Do you have old fillings/dental work you don't like?.......................... Yes No
6. Do you have to take antibiotics before any dental work?...................... Yes No
7. Are you wearing removable dental appliances?.................................... Yes No
8. What is your chief dental complaint?____

1. Are you in good health?... Yes No
2. My last physical examination was on____
3. Are you now under the care of a physician?.. Yes No

If so, what is the condition being treated?____

4. The name and address of my physician(s) is____________________________

*** Please do not overlook this form***
Any questions please ask the front desk.

Sebastian D'Amico, Jr. D.M.D.

*** NOTICE OF HIPA PRIVACY PRACTICES***

Please print your name____ have received a copy of the Hipa privacy practice.

____
Signature

____
Date

____

____

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 acknowledgement

___ Other (Please Specify)

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FINANCIAL POLICY & MISSED APPOINTMENT POLICY

Please understand that payment of your bill is considered a part of your treatment and is due in full at time of service. The following is a statement of our Financial Policy, which we require you to read and sign before any treatment. All patients must also complete our Registration/Medical history and Insurance form before seeing the doctor.

REGARDING INSURANCE:

We may accept assignment of insurance benefits for you. However, **we do require deductibles, and co-payments to be paid at time of service**. We cannot bill your insurance company unless you give us your correct insurance information. Whether your insurance company pays or not the balance is your responsibility as your insurance policy is between you and your insurance company. Please feel free to call them directly to discuss any questions you may have regarding benefits they may process.

In the event, we do accept assignment of benefits we require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 90 days, the balance will automatically be transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services under the conditions of your insurance contract.

Financial Policy & Missing Appointment Policy

Unless notification is given, at least 48 hours in advance, our policy is to charge a $50.00 fee for missed appointments. This is so that we may keep our fees reasonable and still, provide quality dentistry. Please help us serve you better by keeping scheduled appointments.

In consideration of dental treatment to be rendered to me or my dependents, I agree to sign over every dental benefit payment issued to me for dental services performed by this office within ten business days after receipt form a Dental Service Corporation, Health Service Corporation or Dental Plan Organization, provided, however, if the amount owed to this office is less than the amount of the dental benefit payment, then only the balance owed shall be paid.

I understand and agree the Financial Policy & Missing Appointment Policy.

X____ Date
Signature of Patient or Responsible Party

X-- Date
Please print your name, Thank you.

Medical History Form

Patient's Name____ Date________________

If you are completing this form for another person, what is your relationship to that person?__________

1.Are you allergic or have you had a reaction to:

Local anesthetics..Y N

Penicillin or other antibiotics......................Y N

Sulfa drugs..Y N

Barbiturates,sedatives,or sleeping pills....... Y N

Aspirin...Y N

Iodine......................................Y N

Codeine/other narcotics...........Y N

Other..Y N

2. Have you had any serious illness, operation, or hospitalized in the past 5 years? Yes No

If so, what was the illness or problem?______________________________

____

3. Are you taking any medicine(s) including non-prescription medicine.............. Yes No

Please list:______________________________________

For the following questions, check whichever applies. Your answers are for our records only and are considered confidential.

___Allergy/Sinus Trouble

___Aids/HIV+

___Asthma/Hay Fever

___Blood disorder (anemia, etc.)

___Blood transfusion-ever required

___Cancer

___Cardiac pacemaker

___Cardiovascular disease (heart attack, stroke,ect...)

___Chemical Dependency

___High blood pressure

___Damaged/artificial heart valves

___Diabetes

___Epilepsy/ neurological disease

___Fainting spells/Seizures

___Hepatitis, jaundice, or liver disease

___Respiratory problems, emphysema, bronchitis,ect..

___Kidney trouble

___Low blood pressure

___Mitral Valve Prolapse

___ Heart Murmur

___Neurological disease

___Prosthetic Devices (hip,joint,ect...)

___Radiation/Chemo Treatment

___Sexually transmitted disease

___Stomach ulcer or hyperacidity

___Thyroid problems

___Tuberculosis

___Tumor/Growth

Other________________________________

Women: Are you pregnant? Y N

Are you nursing? Y N

Are you taking birth control Y N

***I certify that I have read and understand the above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any member of this staff responsible for any errors or omissions that I may have made.**

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Signature of Patient, or Guardian if under 18years old.