# WELCOME

## 1 ABOUT YOU

Today's Date: ______ / ______ / ______ File #: ______

**Patient Name:** ______ LAST ______ FIRST ______ MI

What You Prefer To Be Called: ______ ❑ Male ❑ Female

Birthdate: ___ / ___ / ___ Age: ______ SS#: ______

Mailing Address: ______

CITY ______ STATE ______ ZIP ______

Home Phone #: (______) ______

Work Phone #: (______) ______ Ext: ______

Cell Phone #: (______) ______

E-mail Address: ______

Referred By: ______

**Employer:** ______ How Long? ______

Employer's Address: ______

CITY ______ STATE ______ ZIP ______

Occupation: ______

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ______

Do you have children? ❑ Yes ❑ No How many? ______

## 2 INSURANCE INFO

### Primary Dental Insurance

Co. Name: ______

Address: ______

CITY ______ STATE ______ ZIP ______

Phone #: (______) ______

Insured's ID#: ______

Group # (Plan, Local, or Policy #): ______

Insured's Name: ______

Relation: ______ Date of Birth: ___ / ___ / ___

Insured's Employer: ______

### Secondary Dental Insurance

Co. Name: ______

Address: ______

CITY ______ STATE ______ ZIP ______

Phone #: (______) ______

Insured's ID#: ______

Group # (Plan, Local, or Policy #): ______

Insured's Name: ______

Relation: ______ Date of Birth: ___ / ___ / ___

Insured's Employer: ______

## 3 ACCOUNT INFO

**Person ultimately responsible for account**

Name: ______

Relation: ______

Billing Address: ______

CITY ______ STATE ______ ZIP ______

SS #: ______

Drivers License #: ______

Work Phone #: (______) ______

**Payment method:** ❑ Cash ❑ Check

______ ___ / ___

❑ Credit Card - Enter card # above (if accepted)

______ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

## 4 EMERGENCY CONTACT

Whom should we contact? ______

Relation: ______

Home Phone #: (______) ______

Work Phone #: (______) ______

Cell Phone #: (______) ______

Who is your Medical Doctor? ______

Medical Doctor's Phone #: (______) ______

CONTINUE ON BACK

## 5 DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation  Are you in pain? ☐ No ☐ Yes  How Long?______
Please indicate ☑ any of the following problems:

☐ Discomfort, clicking or popping in jaw ☐ Lost/Broken Filling(s) ☐ Stained teeth ☐ Broken/Chipped tooth
☐ Blisters/Sores in or around the mouth ☐ Teeth grinding ☐ Locking Jaw ☐ Sensitive tooth, teeth or gums
☐ Red, swollen or bleeding gums ☐ Ringing in Ears ☐ Bad breath ☐ Active Decay/Cavity(ies)
☐ Other: ______

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know  Have you ever been treated for Gum Disease? ☐ Y ☐ N

Previous Dentist: ______ Name ______ Address ______ (____) ______ Phone#

Last Dental exam: ___/___/___ Last Dental X-rays: ___/___/___ Last Dental Cleaning: ___/___/___

Have you had problems with previous dental treatment? If so, explain: ______

Times a day you brush?____ Times a week you floss?____ Type of tooth brush bristles? ☐ Soft ☐ Medium ☐ Hard

Rate your Smile from 1-10: ______ (EXCELLENT=10)  Would you like whiter teeth? ☐Y ☐N  Have you had orthodontic treatment? ☐Y ☐N

Things you would change about your smile? ______

## 6 MEDICAL HISTORY & INFORMATION

**What medications are you taking?** ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis ☐ **Vitamins/Supplements** ______
☐ Other(s), please list: ______

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ☐ Yes ☐ No  Phen-fen/Redux ☐ Yes ☐ No

**Do you have or have you had any of the following diseases, medical conditions or procedures?**

| | | | | |
|---|---|---|---|---|
| **Y N** Heart Murmur | **Y N** Heart Attack/Stroke | **Y N** Heart Surg./Pacemaker | **Y N** Heart Disease/Angina | **Y N** Shingles |
| **Y N** Lung Disease | **Y N** Thyroid Problems | **Y N** Congenital Heart Defect | **Y N** Cancer/Tumor(s)/Growth(s) | **Y N** Hepatitis |
| **Y N** Liver Problems | **Y N** Seizures/Epilepsy | **Y N** Artificial Heart Valves | **Y N** Chemotherapy/Radiation | **Y N** Glaucoma |
| **Y N** Blood Disease | **Y N** Venereal Disease | **Y N** Mitral Valve Prolapse | **Y N** X-ray or Cobalt Treatment | **Y N** Arthritis/Gout |
| **Y N** Kidney Problems | **Y N** Cosmetic Surgery | **Y N** G.I. Problems/Ulcers | **Y N** Frequent Thirst/Urination | **Y N** Leukemia |
| **Y N** Scarlet Fever | **Y N** Dizziness/Fainting | **Y N** Emphysema/Asthma | **Y N** Bleeding Problems/Anemia | **Y N** Chest Pains |
| **Y N** Tuberculosis TB | **Y N** Cold/Fever Blisters | **Y N** Diabetes/Hypoglycemia | **Y N** High/Low Blood Pressure | **Y N** Bruise Easily |
| **Y N** HIV+/AIDS/ARC | **Y N** Blood Transfusion | **Y N** Psychiatric Problems | **Y N** Artificial Bones/Joints/Implants | **Y N** Allergies |
| **Y N** Rheumatic Fever | **Y N** Alcohol/Drug Abuse | **Y N** Back/Neck Problems | **Y N** Severe/Frequent Headaches | **Y N** Nervousness |
| **Y N** Sinus Problems | **Y N** Eating Disorder | **Y N** Respiratory Problems | **Y N** Jaw Problems TMJ/TMD | **Y N** Sleep Apnea |

Please list any other surgeries or medical conditions you have or ever had: ______

Are you allergic to any of the following? ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Codeine
☐ Dental Anesthetics ☐ Foods: ______ ☐ Others: ______

Do you use tobacco? ☐ No ☐ Yes/How used?______ How much?______ How long?______

Please rate your general health from 1-10: ______ Do you wear contact lenses? ☐ Yes ☐ No
**For women:** Are you taking Birth Control pills? ☐ Yes ☐ No  Are you taking hormonal replacement? ☐ Yes ☐ No

Are you Pregnant? ☐ No ☐ Yes/How long?______ Are you nursing? ☐ Y ☐ N  How many children have you had?______

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

______ Initials **I acknowledge that I have received a copy of the Summary of Privacy Notice.**

Signature ______ ☐ Adult Patient ☐ Parent or Guardian ☐ Spouse  Date ___/___/___

**UPDATE (OFFICE USE)**

______ Initials ___/___/___ Date
______ Comments
______ Initials ___/___/___ Date
______ Comments
______ Initials ___/___/___ Date
______ Comments

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Robert M. DiGiorgio, D.D.S.

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

______________________________
Please Print Name

______________________________
Signature

______________________________
Date

**For Office Use Only**

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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ROBERT M. DIGIORGIO, D.D.S., F.A.G.D., P.C.
17821 COTTONWOOD DRIVE
PARKER, COLORADO 80134
303-699-6100

Thank you for choosing us as your **Dental Healthcare Provider**. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.
All patients must complete our Information form before seeing the doctor.

**PATIENT PORTIONS/DEDUCTIBLE IS DUE AT TIME OF SERVICE.**
**WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERCAN EXPRESS, CARECREDIT AND CITIHEALTH CARD.**

**REGARDING INSURANCE**

We may accept assignment of insurance benefits. **We do require that you pay your portion and/or deductible at time of service. The balance is your responsibility whether your insurance company pays or not.** We cannot bill your insurance company unless you give us all your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance.

**BILLING**

**At the beginning of every month you will receive a statement from our billing company First Pacific Corporation. These go out if there is a balance on the account whether or not insurance has paid. If the insurance is pending there is no need to call the office. You will have paid your portion of major dental services while in the office at an estimated amount. You may have a balance due since this was only an estimate. If you believe the insurance has paid its portion and you have any questions please feel free to call.**

**USUAL AND CUSTOMARY RATES**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance's arbitrary determination of usual and customary rates.**

**ADULT PATIENTS**

Adult patients are responsible for patient portion and deductible at time of service.

**MINOR PATIENTS**

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for patient portion and deductible. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, major credit card, or payment by cash or check at time of service has been verified.

## ***MISSED APPOINTMENTS – AVOID CANCELLATION FEES – GIVE 48 HOURS NOTICE***

**Unless cancelled at least 48 business hours in advance, our policy is to charge for missed appointments. The charge is $45.00 per ½ hour of scheduled time. 48 Hours notice gives our office enough time to fill that appointment time. Please help us serve you better by keeping scheduled appointments.**

**Thank you for understanding our financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.**

**X______________________________Signature**     **______________________Today's Date**