Notice of Privacy Practices

Patient Acknowledgement

Patient Name: ______________________________________

Date of Birth: ______________________________________

By signing below I consent to the use and disclosure of my protected health information by DiPiero Family Dental and their business associates (i.e.: insurance companies, dental specialists) for any treatment and payment that is necessary. For a more detailed description of the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information; I may request a copy of DiPiero Family Dental Notice of Information Practices at any time. I understand that this practice reserves the right to change the terms of its Notice of Information Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice.

Also in order to protect your privacy and yet be able to get needed information to you or from you, we need to know the best way to reach you and who we may share information with.

1. May we leave messages on your home phone Yes____ No _____
2. May we leave messages on your work phone Yes____ No_____
3. May we leave messages on your cell phone Yes____ No _____
4. Who else may we discuss treatment or payment with Spouse ____ Parent ____ Physician ____ Someone Else ____________________

Finally, there may be times when Dr. DiPiero will not be at the office due to vacation or illness. The hygienists are all licensed to complete their duties unsupervised. I give my permission for the hygienist to complete her portion of my cleaning and x-rays. If she finds an area of concern, she will schedule further treatment by Dr. DiPiero upon her return.

____

Patient, Parent, or Guardian Signature Date

Written Financial Policy

Thank you for choosing DiPiero Family Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

To keep fees to a minimum and continue to provide the best quality care for our patient, we now ask that patients pay for their treatment with one of the following options at the time of service.

- Cash
- Check
- Credit Card – *Visa, Master Card, Discover*
- Care Credit

There is a $40.00 fee for returned checks ____ (initial). Appointments are reserved especially for you. Kindly give our office a 24 hour notice if you need to reschedule or cancel. **A $50.00 broken appointment or late cancelation fee will be considered if less than 24 hour notice is given _____ (initial).**

Truth & Lending: Finance charges are assessed on all accounts with balances not paid within 60 days at a rate of 1.5%

Please note:

We will continue to submit to your insurance. However, ultimately **it is your responsibility to know your dental benefit coverage and to inform us_____(initial)!** We submit your claims as a courtesy to you. Legally you are responsible for your account. We cannot be responsible for services ***NOT*** covered or balances that have not been paid by your insurance. In the case of an overpayment you will be reimbursed within 30 days of receiving the insurance payment.

Please remember when using insurance, it is considered a method of reimbursing the patient for fees paid to the doctor. It is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company.** Insurance co-payments may change according to the procedures performed and your specific policy. We ask that you pay your ***estimated*** portion at the time of service.

We appreciate your understanding of this policy. We look forward to continuing to serve you and your family's dental health needs.

____

Patient, Parent, or Guardian signature   Date

PATIENT REGISTRATION

Cell Phone #:_______________________ *is it ok to send text message Y N* **Home Phone#:**________________

*Patient:*____

Last *first* *middle* *preferred name*

*Address:*____

Street *city* *state* *zip*

Sex: M/F Age: _____ *DOB*____ /____ /____ *SS#:*_______-_______-________ *Marital: S M D W*

*****E-mail***____

Employer____*Work Phone #*__________________

Who is responsible for the account: _________________________ *Relationship to patient* _________________

Address if different from above: ____

Spouse/Parent Name: _________________________ *Occupation:* _________________________________

Spouse/ Parent employed by: ____

DOB: ____/____/____ *SS#*________-______-______ *Work Phone:* ______________________________

Whom may we thank for referring you: ____

In case of emergency, who should be notified ________________ *Phone #*____________________________

PRIMARY DENTAL INSURANCE

Insured person: ______________________________ *Relationship to patient:* ________________________

Address (if different from above) ____

*SS#*______/_____/______ *Employer:* ____

*DOB*______/_____/______ *GROUP #*_______________*MEMBER ID #*_____________________________

Insurance Company: ___________________________________ __________________________________

Insurance Address: ____

Insurance Co phone # ____

SECONDARY DENTAL INSURANCE

Insured person: ________________ ____________________*Relationship to patient:* ________________

Address (if different from above) ____

*SS#*______/_____/______ *Employer:* ____

*DOB*______/____/______ *GROUP #*___________________*MEMBER ID #*__________________________

Insurance Company: ___________________________________ __________________________________

Insurance Address: ____

Insurance Co. Phone # ____

Signature________________________________ ***DATE***_____________________________

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle* | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: *Mailing address* | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of Birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: *Include area code* ( ) | Cell Phone: *Include area code* ( )

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

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *(Check one:)* DAILY ☐ / WEEKLY ☐ / OCCASIONALLY ☐			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: | Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	**No**	**DK**
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	**No**	**DK**
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

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Form S500

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question) Yes No DK

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐

Date: ____________ If yes, have you had any complications? ____________

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Date Treatment began: ____________

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐

If yes, how much alcohol did you drink in the last 24 hours? ____________

If yes, how much do you typically drink i n a week? ____________

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐
Number of weeks: ____________
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics ____________	☐	☐	☐
Aspirin ____________	☐	☐	☐
Penicillin or other antibiotics ____________	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ____________	☐	☐	☐
Sulfa drugs ____________	☐	☐	☐
Codeine or other narcotics ____________	☐	☐	☐
Metals ____________	☐	☐	☐
Latex (rubber) ____________	☐	☐	☐
Iodine ____________	☐	☐	☐
Hay fever/seasonal ____________	☐	☐	☐
Animals ____________	☐	☐	☐
Food ____________	☐	☐	☐
Other ____________	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: ____________	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: ____________	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: ____________	☐	☐	☐
Recurrent Infections Type of infection: ____________	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: Phone: *Include area code* ( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments: