Zambito FAMILY DENTISTRY

WELCOME TO OUR OFFICES

Our goal is to help you enjoy the benefits of a healthy, happy smile. To better communicate the care you need, please fill out the following questions completely.

1 ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____
APT #

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: _____ Cell _____

Work #: _____ Ext. _____

Employer: _____

Employer's Address: _____

Occupation: _____

Where & when are the best times to reach you? _____

Who may we Thank for referring you? _____

Email: _____

2 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ ID#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ ID#: _____

Insured's Employer: _____

Person Responsible for Account: _____

Work #: _____ Home #: _____

Billing Address: _____

_____
CITY STATE ZIP

Relationship: _____ SS#: _____

Employer: _____

3 SPOUSE INFORMATION

Spouse's Name: _____

Employer: _____

Work #: _____ SS#: _____

Birthdate: ___/___/___ Cell: _____

Email: _____

4 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ No ❑ Yes

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ No ❑ Yes

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ No ❑ Yes

Do your gums ever bleed? ❑ No ❑ Yes

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

Previous/present dentist? _____
(PLEASE CIRCLE)

Last visit date: _____

MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❑ Yes ❑ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes, please explain: _____
Are you taking any medications, pills or drugs? ❑ Yes ❑ No If yes, please explain: _____
Are you on a special diet? ❑ Yes ❑ No _____
Do you use tobacco? ❑ Yes ❑ No
Do you use controlled substances? ❑ Yes ❑ No
Do you take, or have you taken, Phen-Fen or Redux? ❑ Yes ❑ No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? ❑ Yes ❑ No

Women: Are you
❑ Pregnant/Trying to get pregnant?
❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Sulfa
❑ Other, please explain: _____

Do you have, or have you had, any of the following?

- ❑ Acid Reflux
- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problems
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur
- ❑ Heart Pace Maker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Sleep Disorders
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Tumers or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____

CONSENT FOR TREATMENT

I hereby authorize doctor or designed staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of patient's dental needs. Upon such diagnosis, I authorize the doctor to perform all the recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Signature of Patient/Parent/Guardian_____ Date_____

FINANCIAL GUIDELINES

I understand that: 1) Full payment is due at the time of service. 2) **All charges are ultimately the responsibility of the patient/guarantor/ (regardless of insurance).** 3) A third party (with the exception of insurance companies) will not be billed for any amount due to this office. Custodial parents are guarantors for children: this office is not party in domestic settlements. 4) In the event payment is not made by the due date, a late charge fee may be added to the patient's account. 5) Any collection fees incurred by this office in an attempt to obtain payment, or bank fees for a returned check, or fees for an appointment missed or broken with less than 48 hours notice will be paid by the patient/guarantor.

ADDITIONAL POLICES PERTAINING TO INSURANCE:

I understand that: 1) We cannot bill your insurance company unless we are given the correct information. This includes subscriber's name and date of birth, subscriber's employer, correct identification number, and mailing address of the insurance company. 2) The patient/guarantor is responsible to pay for all services rendered on the behalf if insurance does not pay within 60 days of date of service. 3) Any deductible and/or co-insurance is due at time of service. **4) This office is not contracted with any insurance as a networked provider. Therefore, any fee or portion of a fee not covered by insurance is the patient's/guarantor's responsibility to pay.** Acceptance of insurance assignment of benefits to this office does not absolve the patient of full responsibility of payment for treatment rendered. Any estimate given by this office regarding insurance portion is only a guideline until guarantee of the insurance payment is received and the patient's account has been reconciled. **This office makes no guarantee of the insurance payment as estimated.** 5) Any patient/guarantor whose insurance carrier does not honor assignment of benefits to the provider of service must pay this office in full at the time of the services rendered. This office makes no guarantee of the insurance payment as estimated.

APPOINTMENTS

Please be courteous and help us serve you better by keeping scheduled appointments**. It is your responsibility to call 48 hours in advance to cancel your appointment.** Your dental care is a team effort and we need your help to keeping your dental health at its best.

I certify that I have read and do hereby agree to the above stated information.

Patient_____ Date _____

Parent or Responsible Party_____Date_____

Late Cancellation and No-Show Policy

We understand that situations arise in which you must cancel a previously scheduled appointment; however, we kindly request that you provide our office with at least 48 hours notice for a cancellation. This is a courtesy that allows us to use that appointment time to serve other patients, especially same day emergency patients.

Please be advised that there is a possibility of a $30 fee per ½ hour that is scheduled for your appointment time if not enough notice is given.

~ Thank You ~

To cancel or change your appointment, please call (304) 243-1500

Patient signature _____

Witness _____

Please be considerate of all our patients, so we can serve everyone properly.

January 2020

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information.

These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my Treatment).
Obtaining payment from third party payers (e.g. my insurance company)
The day to day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my right under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I also understand that the office of Zambito Family Dentistry can text the cellular number provided on the paperwork with updated appointment information and account information.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____, 20___.

Print Patient Name: _____

Relationship to Patient:_____

Signature: _____

Practice Name: Zambito Family Dentistry, PLLC

Address: 1201 Mt De Chantal Road

City/State/Zip Wheeling, WV 26003