



## Patient Profile

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Pref. Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ Previous Dentist \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Work # \_\_\_\_\_ Ext \_\_\_\_\_ Occupation \_\_\_\_\_

Email \_\_\_\_\_ Emergency Contact \_\_\_\_\_

Phone # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Appointment Preference

How do you prefer to be reached:  Home #  Cell #  Text to Cell #  Work #  Email

My preferred appointment times are:  Morning  Afternoons  Evenings  No Preference

## Referral Profile

How did you hear about our office? \_\_\_\_\_

## Insurance Profile

Name of Insured \_\_\_\_\_ Relationship to Patient  Self  Spouse  Child  Other

Insured Soc. Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_

Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_



### Medical History

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Physician \_\_\_\_\_ Date Last Physical Exam \_\_\_\_\_

- Have you ever been hospitalized or had a major injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have taken, Phen-Fed or Redux?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you use tobacco?  Yes  No If yes, please explain: \_\_\_\_\_

Are you allergic to any of the following?

- Aspirin, Motrin, Tylenol
- Penicillin
- Codeine
- Local Anesthetics
- Acrylic
- Metal
- Latex
- Other: If yes, please explain \_\_\_\_\_

Women, are you:

- Pregnant/Trying to get pregnant?  Yes  No
- Taking oral contraceptives?  Yes  No
- Nursing?  Yes  No

Do you have or have had any of the following?

- |                             |  |                        |  |                        |  |                     |  |
|-----------------------------|--|------------------------|--|------------------------|--|---------------------|--|
| AIDS/HIV Positive           | <input type="radio"/> Yes <input type="radio"/> No | COPD / Lung Disease    | <input type="radio"/> Yes <input type="radio"/> No | Heart Disease          | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever     | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease         | <input type="radio"/> Yes <input type="radio"/> No | Depression             | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis (Type _____) | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever       | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis                 | <input type="radio"/> Yes <input type="radio"/> No | Diabetes               | <input type="radio"/> Yes <input type="radio"/> No | Herpes                 | <input type="radio"/> Yes <input type="radio"/> No | Shingles            | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia                      | <input type="radio"/> Yes <input type="radio"/> No | Digestive Disorders    | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure    | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Angina/Chest Pains          | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction         | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol       | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble       | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout              | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded          | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash          | <input type="radio"/> Yes <input type="radio"/> No | Sleep Apnea         | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve      | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy / Seizures    | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia           | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida        | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint            | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst       | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems        | <input type="radio"/> Yes <input type="radio"/> No | Stroke              | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma                      | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells        | <input type="radio"/> Yes <input type="radio"/> No | Leukemia               | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs   | <input type="radio"/> Yes <input type="radio"/> No |
| Bleeding Problems           | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough         | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease          | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease     | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion           | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea      | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure     | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis         | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem           | <input type="radio"/> Yes <input type="radio"/> No | Gastric Reflux (GERD)  | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse  | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis        | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily               | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma               | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis           | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths   | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy                | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever              | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease    | <input type="radio"/> Yes <input type="radio"/> No | Ulcers              | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores / Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack / Failure | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care       | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease    | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder   | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur           | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments   | <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice     | <input type="radio"/> Yes <input type="radio"/> No |
| Cortisone Medicine          | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker        | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis         | <input type="radio"/> Yes <input type="radio"/> No | Weight Gain/Loss    | <input type="radio"/> Yes <input type="radio"/> No |

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

Please List all medications, supplements, and vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Signature of Patient or Guardian: \_\_\_\_\_ Date \_\_\_\_\_



## Dental History

What is your immediate concern? \_\_\_\_\_

Previous Dentist \_\_\_\_\_ How Long Were You a Patient \_\_\_\_\_ Months / Years

I Routinely Saw My Dentist Every:  3 months  4 months  6 months  12 months  Not Routinely

Please check off all the things that would keep you from pursuing your dental treatment:

Cost  Fear  Lack of Time  Lack of Importance  Other \_\_\_\_\_

Please answer the following questions so that we may get to know you better:

### PERSONAL HISTORY

- Have you ever had an unfavorable dental experience?  Yes  No
- Have you ever had complications from past dental treatment?  Yes  No
- Have you ever had trouble getting numb in the past?  Yes  No

### SMILE CHARACTERISTICS

- Are you self-conscious about the appearance of your teeth?  Yes  No
- Would you like your teeth to look whiter?  Yes  No
- Have you ever had orthodontics in the past?  Yes  No
- Do you like the shape of your teeth?  Yes  No
- Are you happy with the appearance of your lips?  Yes  No
- Are you interested in Botox and/or Juve'Derm?  Yes  No

### BITE AND JAW JOINT

- Have your teeth become shorter, thin, worn in the last 5 years?  Yes  No
- Do you have problems with your jaw joint?  Yes  No
- Do you or have you ever worn a bite appliance?  Yes  No

### TOOTH STRUCTURE

- Have you ever had a toothache, cracked filling, or broken tooth?  Yes  No
- Are any teeth sensitive to hot, cold, biting, or sweets?  Yes  No
- Do you avoid brushing any part of your mouth?  Yes  No
- Do you have a dry mouth?  Yes  No
- Have you ever had a tooth extracted?  Yes  No

### GUM AND BONE

- Have you ever been diagnosed or treated for periodontal (gum) disease?  Yes  No
- Is there anyone in your family with a history of periodontal disease?  Yes  No
- Have you ever experienced gum recession?  Yes  No
- Do your gums bleed when brushing, flossing, or eating?  Yes  No
- Have you ever noticed an unpleasant taste or odor in your mouth?  Yes  No

Signature of Patient or Guardian: \_\_\_\_\_ Date \_\_\_\_\_



## HIPAA Authorization

I, (Patient Name or Legal Guardian) \_\_\_\_\_, authorize the practice of Dr. DiPilla & Associates and its staff to provide medical treatment and to release information related to patient treatment, payment, or health care operations.

I further acknowledge receipt of this practice's Notice of Privacy Practices and rights to review the Provider's Privacy Requirements.

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

## Office Policies

At our office we believe in devoting our entire focus towards each patient. Please understand for this to happen we specifically reserve time in the schedule for your treatment needs. Due to the high demand for these appointment slots, the following office policies have been instituted:

**THERE WILL BE A \$50 FEE CHARGED TO YOUR ACCOUNT IF YOU FAIL TO MAKE YOUR HYGIENE APPOINTMENT OR DO NOT CALL THE OFFICE WITHIN A 24 HOUR PERIOD TO CANCEL.**

**IF YOU HAVE RESERVED TIME WITH DR. DIPILLA, THE FEE WILL BE ASSESSED BASED ON YOUR TREATMENT PLAN AND THE LENGTH OF THE APPOINTED TIME MISSED.**

**IF YOU ARE MORE THAN 15 MINUTES LATE FOR YOUR APPOINTMENT AND WE ARE UNABLE TO PERFORM THE PLANNED TREATMENT IN THE TIME REMAINING, WE WILL NEED TO RESCHEDULE YOUR APPOINTMENT.**

Our staff wants to be available for your needs and the needs of all our patients, however, when a patient does not show up for a scheduled appointment, another patient misses the opportunity to be seen.

We thank you for being a valued patient and for your understanding of these office policies.

Signature of Patient or Guardian: \_\_\_\_\_ Date \_\_\_\_\_



## **Our Financial Policy**

### **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 company's arbitrary determination of usual and customary rates.

**FULL PAYMENT IS DUE AT TIME OF SERVICE.**

**WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.**

**WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.**

### **Regarding Insurance**

You are responsible for payment of all services rendered. Payment in full is required at the time of service. We may accept assignment of your insurance benefits, but please understand your insurance policy is a contract between you and your insurance company. We have no influence in the terms agreed upon between you and your insurance company. We are happy to submit your insurance claim but we will need all of your insurance information. Failure to do so prohibits any claim submission and the entire balance will be due immediately. If a portion of your treatment will be covered by your insurance, we require your co-pay portion to be paid at the time of service. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. The balance is your responsibility whether your insurance company pays or not. Please be aware some of the services provided may be non-covered services by the Insurance Program and/or other medical insurance. This is not a statement by the insurance company that the service was unnecessary, but rather a reason for rejection of payment by the insurance company.

### **Missed Appointments**

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Guardian: \_\_\_\_\_ Date \_\_\_\_\_