di pilla

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