WELCOME TO OUR PRACTICE

Thank you for selecting us to care for your oral health. We strive to provide our patient with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form to the best of your ability.

PATIENT INFORMATION

Patient's name ____ Preferred name _________________
Circle one: Male/Female Single/Married/Divorced/Widowed
Patient SSN _______________________________ Patient Date of Birth ____________________
If minor, parent's name (responsible party) ____
Parent SSN _______________________________ Parent Date of Birth _____________________
Home Phone ______________________Cell Phone _______________________
Work Phone __________________Email________________
Preferred method of contact ____
Mailing Address ____
City_____________________________ State_________ Zip_____________
Other family members seen by us ____
Whom may we thank for referring you to our office? ____
Emergency Contact (Neighbor or relative not living with you):
Name _______________________________________ Relation ________ Phone _____________________

☐ Not covered by dental insurance

PRIMARY DENTAL INSURANCE

Subscriber Name _____________________________________
Subscriber Date of Birth __________________
Patient Relationship to subscriber _______________
Subscribers Employer _____________________
Dental Insurance Company ____
Identification Number (SSN) _____________________Group Number ________________________

SECONDARY DENTAL INSURANCE

Subscriber Name _____________________________________
Subscriber Date of Birth __________________
Patient Relationship to subscriber _______________
Subscribers Employer _____________________
Dental Insurance Company ____
Identification Number (SSN) _____________________Group Number ________________________

MEDICAL HEALTH HISTORY

Patient's Name: **Date Of Birth:**

Do you have or Have you had any of the following?
Please check any that apply
☐ Cancer or tumor-Type/Date________________________
☐ Heart attack or stroke-Date________________________
☐ Heart murmur, mitral valve prolapse, heart defect
☐ High or low blood pressure
☐ Pacemaker
☐ Tuberculosis or lung problems
☐ Kidney disease
☐ Hepatitis-Type A B C (Circle)
☐ History of Alcoholism/Chemical Dependency (Circle)
☐ Blood transfusion
☐ Diabetes Type 1 or Type 2 (Circle)
☐ Neurologic condition
☐ Epilepsy, seizures, or fainting spells
☐ Diagnosed Psychological condition __________________
☐ Arthritis
☐ Herpes or cold sores
☐ AIDS or HIV positive
☐Migraine headaches or frequent headaches
☐ Anemia or blood disorders
☐ Abnormal bleeding after extractions, surgery or trauma
☐ Allergies/Sinus Trouble
☐ Asthma
☐ ADD/ADHD/Autism (Circle)
☐ Other ____

Have you ever been a patient in the hospital or had any serious illnesses?(excluding childbirth) ☐yes ☐no
If yes, please list illness and approximate date:
____
____
____
____

Are you **allergic** to, or have you reacted adversely to any of the following?
☐ Latex materials
☐ Penicillin or other antibiotics
☐ Local anesthetics
☐ Codeine or other narcotics
☐ Sulfa drugs
☐ Barbiturates, sedatives, or sleeping pills
☐ Aspirin
☐ Other ____

Are you taking any of the following **medications**?
☐ Aspirin **If yes, dose/how often?* _____________________
☐ Anticoagulants (blood thinners)
☐ Antibiotics or sulfa drugs
☐ High blood pressure medicine
☐ Antidepressants or tranquilizers
☐ Insulin, Orinase, or other diabetes drug
☐ Nitroglycerin **If yes, how often?* _____________________
☐ Cortisone or other steroids

Have you **in the past or are you currently** taking Osteoporosis (bone density) medicine? ☐yes ☐no
Medication Name?___________________________
Do you smoke or use chewing tobacco? ☐yes ☐no
Have you ever had a joint or heart valve replacement? ☐yes ☐no
If yes, approximate date: _____________________
Have you ever taken a pre-medication prior to dental care? ☐yes ☐no
FOR WOMEN:
☐ Pregnant or may be pregnant
Expected due date____________________________
☐ Taking hormones or contraceptives ☐yes ☐no

List of all medications (prescribed, supplement, or over the counter) you are currently taking (if you have a list, please provide to front desk) ____

Name of Physician Phone #

Name of Previous Dentist_________________________________ Last visit?_____________ Date of recent xrays?______________
Reason for leaving?____
Do you have routine dental examinations? ☐yes ☐ no
How often do you brush?________________ How often do you floss?________________ Do your gums bleed?_______________
Do you have jaw pain? ☐yes ☐ no Do you clench or grind your teeth? ☐yes ☐ no
Are you happy with the color and/or appearance of your smile? ☐yes ☐ no If no, why not? _________________________

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any future changes in my medical status.

Signature of Patient (or responsible party) ____ **Date** ____________

Signature of Doctor (health history reviewed) ____ **Date** _____________

CONSENT/AUTHORIZATION/ACKNOWLEDGMENT

Patients under 18 must be accompanied by a parent/guardian.

CLINICAL- I authorize Dr. Lance Pietropola to take necessary radiographs and other diagnostic aids as needed to make a thorough diagnosis. I authorize such to be mailed to referring providers or insurance companies. I authorize this practice to perform all recommended and agreed upon treatment. I also authorize the use of anesthetics sedatives and other medication (as needed) and am fully aware that using anesthetic agents involves certain risks.

FINANCIAL- I am responsible for payment for all services rendered on my behalf and my dependents. I have been informed that payment is due when services are rendered. I am aware that should my account become delinquent, I will assume all additional collections costs and legal fees.

If you do not have dental benefit coverage, the following financial options apply:

- For treatment requiring multiple appointments, fees may be divided up into multiple payments based on the number of appointments necessary to complete treatment.
- We accept Visa/Mastercard/Discover/CareCredit
- Healthy Smiles Savings Plan through our office.

BROKEN APPOINTMENTS- 48 hours notice must be given before cancelling an appointment. If an appointment is missed or sufficient notice is not given, we reserve the right to charge your account $35 for the first missed appointment and $70 thereafter. If **you fail two consecutive appointments**, you will be placed on our short call list, and called if we have an opening that day to see if you are available, but will not be rescheduled for 12 months. If you repeatedly miss appointments, we reserve the right to dismiss you as a patient in our practice.

INSURANCE- I authorize Dr. Lance Pietropola to submit claims for payment for services rendered or pre-authorization necessary to my insurance company. Also, to release to staff, insurance companies, any and all information, records and radiographs about my medical history, services rendered and treatment necessary. I understand that I am ultimately responsible for payment regardless of the coverage provided. I understand I am responsible for the deductible, co-payment and excess over maximum the day of services. I understand that the dental benefits are a contract between the insurance carrier and me. As such, I am responsible for the full amount of all fees incurred for dental treatment. I agree that any unpaid fees can be turned over to an attorney, district justice, or collection agency, and I agree that I shall pay all costs incurred in the collection of this debt.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY

HIPPA: Consent for Use and Disclosure of Health Information:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at **(717)292-5131** or by mailing us at **3201 Carlisle Road Dover, PA 17315**.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I HAVE READ AND CONSENTED TO ALL OF THE ABOVE

Signature of Patient/Parent/Guardian: ____Date: ___________

Print Name:_______________________________________

Please list the names of individuals you permit to disclose your protected health information (spouse, guardian, etc):