DeStefano DENTISTRY

● **P:** 585-248-2383 ●
DeStefanoDentistry.com
● 600 Kreag Road, Pittsford, NY 14535 ●

PATIENT INFORMATION

Date: ☐New Patient ☐Update

Patient:

Last First MI Preferred Title

☐Male ☐Female ☐Child* ☐Student** ☐Single ☐Married ☐Divorced ☐Widowed

*If Child, provide parent/guardian name(s) below:

Parent/Guardian Name(s)

**If Student, please complete: ☐Full-time ☐Part-Time

School/Location

Patient Date of Birth: Patient SSN:

Address:

Address Line 1

Address Line 2

City ST ZIP Code

Home:
Cell:
Other:
Pager:
Fax:

E-Mail:

Referral? ☐Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

Name Relationship

Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

Address:

Address Line 1

Address Line 2

City ST ZIP Code

Work: X
Direct:
Other:
Pager:
Fax:

E-Mail:

INSURANCE INFORMATION

Subscriber:

Last First MI Preferred Title

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Primary Insurance Carrier:

Group/Policy No.: ID No.:

Address:

City ST ZIP Code

Tel:
Toll-free:
Fax:

Secondary Insurance Carrier:

Group/Policy No.: ID No.:

Address:

City ST ZIP Code

Tel:
Toll-free:
Fax:

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PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Address: _____

_____

CITY ST ZIP CODE

Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: _____ Please email last dental x-rays to **doctordestefano@gmail.com**

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Orthodontic appliances now or in the past?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N

Any additional concerns/comments?

_____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier)
☐Y☐N Any unusual speech habits? If yes, explain: _____
☐Y☐N Any lost teeth? If yes, list: _____
☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

_____

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Have you ever been hospitalized or had a major operation? _____
☐Y☐N Have you ever had a serious head or neck injury? _____
☐Y☐N Taking any prescription or daily OTC medications? Please list:

_____

☐Y☐N Do you take, or have taken, Phen-Fen or Redux? _____
☐Y☐N Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? _____
☐Y☐N Are you on a special diet?
☐Y☐N Use tobacco in any form? If Yes, Type:
☐Y☐N Do you use controlled substances?

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FEMALE PATIENTS: ☐Y☐N Pregnant/Trying to get pregnant? ☐Y☐N Nursing? ☐ORAL CONTRACEPTIVES

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN ☐CODEINE ☐PENICILLIN/OTHER ANTIBIOTICS ☐NONE
☐ANESTHETIC – LOCAL ☐METAL ☐SULFA DRUGS
☐LATEX ☐ACRYLIC
☐OTHER – PLEASE LIST:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐AIDS/HIV POSITIVE
☐ALZHEIMER'S DISEASE
☐ANAPHYLAXIS
☐ANEMIA
☐ANGINA
☐ARTHRITIS/GOUT
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐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/SEIZURES
☐DEPRESSION
☐EXCESSIVE BLEEDING
☐EXCESSIVE THIRST
☐FAINTING/DIZZINESS
☐FREQUENT COUGH
☐FREQUENT DIARRHEA
☐FREQUENT HEADACHES
☐GENITAL HERPES
☐GLAUCOMA
☐HAY FEVER
☐HEARING PROBLEMS
☐HEART ATTACK/FAILURE
☐HEART MURMUR
☐HEART PACEMAKER
☐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
☐OTHER – PLEASE LIST:
☐RADIATION TREATMENT
☐RECENT WEIGHT LOSS
☐RENAL DIALYSIS
☐RHEUMATIC FEVER
☐RHEUMATISM
☐SCARLET FEVER
☐SHINGLES
☐SICKLE CELL DISEASE
☐SINUS TROUBLE
☐SPINA BIFIDA
☐STOMACH DISEASE
☐STROKE
☐SWELLING OF LIMBS
☐THYROID DISEASE
☐TONSILLITIS
☐TUMORS OR GROWTHS
☐ULCERS
☐VENEREAL DISEASE
☐YELLOW JAUNDICE

☐ADHD ☐AUTISM/ASPERGER'S

By signing below, I certify that the information above is accurate and complete to the best of my knowledge.

Signature:_____ **Date:** _____

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Financial Policy

Welcome to our practice. Thank you for choosing us as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimal oral health. The following is a statement of our financial policy. Please read, understand and accept what is described below.

- Payment:
  - Payment is due at the time of service. We do accept cash, personal checks, major credit cards, debit cards and third-party financing through *Care Credit.*
- Insurance:
  - As a courtesy to all of our insured patients, we are happy to file your dental insurance claims.
  - Our office participates with Excellus Blue Cross Blue Shield. *We are considered out of network with all other insurance companies*. We ask that you pay the deductible, co-payment and co-insurance, which is the estimate amount not covered by your insurance company at the time we provide the service to you.
  - All charges you incur are your responsibility, regardless of your insurance coverage. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Please contact your insurance company for a detail of your benefits. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company.
  - Insurance payments are ordinarily received within 30-60 days from time of filling a claim. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time and will pursue payment yourself by contacting your insurance company directly.
- Delinquent Account:
  - Any outstanding amount on your account is subject to a 1.5% monthly charge when not paid upon receipt. Accounts over 90 days past due can be referred out for collection and the patient will be responsible for any fees associated with that.
- Returned Checks:
  - A $65.00 fee will apply to all returned checks, in addition to the amount originally owed.
- Missed Appointment (s) and Cancellation Policy:
  - In order to provide the best services to our patients, we require at least 24-hour notice for cancellations or for re-scheduling your appointment. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A $65.00 charge can be applied to your account for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

I have read, understand and agree to the above terms and conditions. I hereby authorize the release of any dental information necessary to process insurance claims. I authorize my insurance company to pay my dental benefits directly to DeStefano Dentistry.

Patient/Responsible Party Signature Name Date