DESTEFANO DENTISTRY

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

Email: ______________________________

Referral? ☐ Yes ☐ No Referred by: ______________

Home: ______________

Cell: ______________

Other: ______________

Pager: ______________

Fax: ______________

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

Email: ______________________________

Work: ______________

Direct: ______________

Other: ______________

Pager: ______________

Fax: ______________

INSURANCE INFORMATION

Subscriber: ____________________
Last | First | MI | Preferred | Title

Subscriber Date of Birth: ____________________ Subscriber SSN/ID: ____________________

Subscriber Employer: ____________________

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

Primary Insurance Carrier: ____________________

Group/Policy No.: ____________________ ID No.: ____________________

Address: ____________________
Address Line 1
____
Address Line 2
____
City | ST | ZIP Code

Tel: ____________________

Toll-Free: ____________________

Fax: ____________________

Secondary Insurance Carrier: ____________________

Group/Policy No.: ____________________ ID No.: ____________________

Address: ____________________
Address Line 1
____
Address Line 2
____
City | ST | ZIP Code

Tel: ____________________

Toll-Free: ____________________

Fax: ____________________

PREVIOUS DENTIST INFORMATION

Dentist: ____________________ Tel: ____________________

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: office@destefanodentistry.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, list here: ______________________

☐ Y ☐ N Do you use controlled substances?

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): ☐ NONE

☐ Aspirin	☐ Codeine	☐ Penicillin/Other Antibiotics	☐ Anesthetic – Local
☐ Latex	☐ Acrylic	☐ Metal	☐ Sulfa Drugs

☐ 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	☐ Diabetes	☐ Hemophilia	☐ Radiation Treatment
☐ Alzheimer's Disease	☐ Drug Addiction	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxi	☐ Easily Winded	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Emphysema	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Epilepsy/Seizures	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis/Gout	☐ Depression	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Joints	☐ Excessive THirst	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Asthma	☐ Fainting/Dizziness	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach Disease
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tonsilitis
☐ Chest Pains	☐ Hearing Problems	☐ Osteoporosis	☐ Tumors or Growths
☐ Cold Sores/Fever Blisters	☐ Heart Attack/Failure	☐ Pain in Jaw Joints	☐ Ulcers
☐ Congenital Heart Disorder	☐ heart Murmur	☐ Parathyroid Disease	☐ Venereal Disease
☐ Convulsions	☐ Heart Pacemaker	☐ Psychiatric Care	☐ Yellow Jaundice
☐ Cortisone Medicine	☐ Heart Trouble/Disease	☐ Other – Please List: ____________	
☐ 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

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