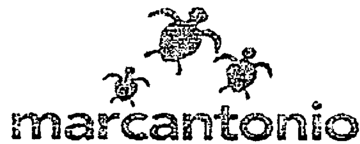

Patient Registration

Date____________________ (Please Print)

Patient____
(Last Name) (First Name) (MI)

Email:____
Home Phone#____________________Cell#____________________SS#____________________
Mailing Address____________________________City____________ State____Zip__________
Physical Address____________________________City____________State____Zip__________
Sex:___M___F Age:_______Birthdate________________Marital Status________________
Employer__________________________________Occupation____________________________
Business Address__________________________________Business Phone#________________
Spouse Name____________________________Birthdate____________SS#________________
Spouse Employer__________________________________Occupation____________________
Business Address______________________________Business Phone #________________
Emergency Contact ____________________________________Phone#____________________
Who is responsible for this account?__________________Relation to Patient______________
Name of Dental Insurance Co.________________________Group#____________________
Id#_______________________Subscriber of Insurance__________________________________

Who may we thank for referring you? ____

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

____
Signature of patient, parent, or guardian Date Relationship to Patient

Dental/Medical History Form

Name: ______________________________ Date: ________________

Sex: Male / Female Height: ________ Weight: ______ DOB ____/____/____

If you are completing this form for another person, what is your relationship to that person: ____________________

1. What is your primary dental complaint? ______________________________
2. When was your last dental cleaning? ____________ Your last complete dental exam? __________ Your last Full mouth X-Ray? ____________
3. Do you have any uncompleted treatment from your last dental visit? ____________________
4. Are you satisfied with your smile? Yes /No If No, Why? ____________________

____

5. Have you ever been told you have, or have had symptoms of gum disease (bleeding gums, sore gums, bad taste or odor in the mouth, loose teeth)? Yes/ No
6. Do you suffer from frequent migraine headaches or have problems with your Jaw Joint? Yes No

For the following questions please circle all answers that apply, if none apply please check none.

Do you have, or have you ever had any of the following: Circle all that apply

Heart Murmur	Rheumatic Fever	Vascular Shunt	High Blood Pressure	Coronary Occlusion
Arteriosclerosis	Stroke	Heart Attack	Chest Pain	Artificial Heart Valves
Heart Defect	Pacemaker	Heart Surgery	Congestive Heart Failure	Chemotherapy/Radiation Treatments
AIDS/ HIV	Hepatitis	Tuberculosis	Sexually Transmitted Disease	NONE

Are you allergic to any of the following: Circle all that apply

Penicillin	Sulfa	Erythromycin	Local Anesthetics	Other Medicine
Codeine	Nickel/Other Metals	Latex	Foods	No Allergies

Do you have, or have you ever had, any problems with the following: **Circle all that apply**

Sinus Trouble	Asthma	Bronchitis	Emphysema	Other Respiratory Problems
Diabetes	Thyroid Disorder	Liver Problems	Kidney or Adrenal Problems	Jaundice
Digestive Problems	Colitis	Stomach Ulcer	Hiatal Hernia	Dry Mouth
Neurological Problems	Fainting	Seizures	Epilepsy	Psychiatric Care
Depression	Abnormal Bleeding	Clotting Problems	Phlebitis	Blood Transfusions
Cancer	Tumor(s)	Cyst	Biopsy	Dizziness
Arthritis	Artificial Joints	Muscle or Bone Disease	Difficulty swallowing	
Are you Pregnant?	Taking Birth Control?	Nursing?		NONE

Do you: Circle all that apply

Smoke	Drink Alcohol	Use Illegal Drugs	Use Chewing Tobacco/Snuff			

Have you ever been: Hospitalized Operated on

Treated for any other conditions not on this form? ____________________

Are you currently taking any of the following:

Steroids Tranquilizers Aspirin Blood Pressure Medication Thyroid Medicine

List All Medications you are currently taking: ________________________________

____

____

____

____

____

____

____

I understand that this medical history is a legal document and that I have answered all of the above questions to the best of my ability and knowledge and I will not hold my dentist or any other staff members responsible for any errors or omissions I have made in the completion of this form.

Signature of Patient or Legal Guardian X________________________________

Financial Policy

Please be aware that the parent bringing the child to our office is responsible for payment of all charges. We cannot send statements to other persons. We ask that you pay the cost of the initial examination and any necessary dental x-rays on the day of that appointment. Please understand that financial arrangements are made directly with you. For the convenience of our patients, the following outlines our financial policies:

1. Payment is due in full for each appointment as services are rendered. We accept cash, personal checks, MasterCard, Visa, Discover, and CareCredit. A charge of $35.00 will be assessed on checks returned for any reason. You will be responsible for payment of all costs and fees incurred, including attorney's fees, should collection efforts be made in order to fulfill a debt.
2. Dental Insurance: It is our policy to accept assignment of benefits for dental insurance, provided the insurance carrier pay benefits directly to the doctor. The type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company; we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. We are currently providers for United Concordia, Delta Dental Premier, Cigna, MetLife, Aetna, Guardian and Principal.
3. Change of Insurance or Self Pay Status: **As of August 18, 2010** if your dental insurance or self pay status changes and you become Medicaid eligible, we will not accept Medicaid as a form of payment. However, Dr. Catherine Marcantonio reserves the right to utilize Medicaid in specific situations. Situations in which the child's needs would best be met in a hospital setting. This determination is based on several factors such as severity of decay, age, and behavior.
4. Pre-treatment Authorization: Some insurance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with the treatment before the insurance benefit is determined.
5. Fillings: Our dental material of choice is a white (composite resin) filling. Please be aware that your insurance company may not pay for a resin filling at the same level as silver (amalgam filling). The co-payment is your responsibility. In some cases, the dentist may recommend placing a silver crown instead of a resin filling.
6. Nitrous Oxide (laughing gas): Nitrous oxide is not always covered by dental insurance. We thank you for your payment at the date of service.
7. Appliances: The entire cost of the appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the laboratory bills when appliances are ordered, not when they are completed.
8. Emergency Treatment: All emergency treatment must be paid in full at the time the service is rendered.
9. Appointments: You are required to give our office 24 hours notice to cancel an appointment. If 24 hours notice is not given, then a $25.00 cancelation fee will be applied to your account. This fee must be satisfied before you are scheduled for another appointment.
10. *Please remember, even if you have insurance coverage, you are responsible for payment of your account. Please realize that your insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated. You are helping us keep our overhead expenses, in the form of direct and labor costs, down. In addition, you are helping keep your fees as low as possible. Past due accounts are subject to a monthly service charge and will be turned over for collection by an outside agency. You agree to pay any and all attorney fees associated with the collection of monies due. I have read and understand my obligation.*

*Signature:*________________________________ *Date:*__________________

Notice of Privacy Practices-HIPPA

Disclosure of Health Information

We use and disclose health information about your child for treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency we will disclose information based on our professional judgment. We may use your child's health information to obtain payment for services. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders or treatment recommendations (such as voicemails, postcards, emails, or letters).

Patients Rights

Access: You have the right to look at or get copies of your health information. If you request a copy we will charge you for each page for staff time to locate and copy the information, and postage if you want the copies mailed.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of information.

Alternative Communication: You have the right to request that we communicate with you about your health history in alternative means.

Amendment: You have the right to request that we amend your health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request to amend or restrict the disclosure of health information you may submit a written complaint to the US Department of Health and Human Services. If you have any further questions about our privacy practices please contact Dr. Marcantonio.

Signature: ____________________________________ Date:______________________