Greece Family Dentistry & Implantology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify:

_____

_____

_____

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Home phone _____ Cell phone _____

Email Address_____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____Work phone _____

Social Security number _____ Whom may we thank for referring you to our office?_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart disease or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Stroke
- ❑ Heart attack
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis
- ❑ Lung disease/ emphysema
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Sexually transmitted disease
- ❑ Stomache ulcers/ GERD
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Radiation therapy
- ❑ Glaucoma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Thyroid problems
- ❑ Other:_____

❑ Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin
- ❑ Other Antibiotic (please list)_____
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Please list all medication you are currently taking including non-prescription medicine:

_____

_____

_____

Women:

- ❑ Are you pregnant or think you may be pregnant? Expected delivery date: _____
- ❑ Are you nursing?
- ❑ Taking hormones or contraceptives?

_____

PATIENT DENTAL HISTORY

Do you snore or stop breathing in your sleep? Yes/ No

- ❑ My gums bleed while brushing or flossing
- ❑ My teeth are sensitive to hot or cold liquids/foods
- ❑ I feel pain in my teeth
- ❑ I have sores or lumps in or near my mouth
- ❑ I have been diagnosed with gum disease
- ❑ I have frequent headaches
- ❑ I clench or grind my teeth
- ❑ I bite my lips or cheeks frequently
- ❑ I've had difficult extractions in the past
- ❑ I've had orthodontic treatment
- ❑ I've had head, neck or jaw injuries
- ❑ I've experienced the following problems in my jaw:
  - ❑ Clicking
  - ❑ Pain (joint, ear, side of face)
  - ❑ Difficulty in opening or closing
  - ❑ Difficulty in chewing
- ❑ I've had no instruction on the correct method of brushing my teeth
- ❑ I've had no instruction on the proper care of my gums

Name of your physician:_____Office Phone:_____Date of last exam:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Signature of patient (or parent) _____ Date _____

Office Policy and Procedure

Our Doctors, Dental Hygienists, and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented policies to accommodate all our patient's needs:

If a patient is more than 15 minutes late for a reservation, the reservation may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. This patient may be given the option to wait for another reservation time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

To be Respectful of our patient's time and the doctor's schedule, we require at least 24 hour advanced notification. If you are unable to honor your commitment or need to cancel your reservation, you will incur a $25.00 cancellation fee.

For those patients who have a reservation that are two hours or longer there will be a non-refundable $50.00 deposit required.

Any questions or concerns please contact our front desk.

FINANCIAL INFORMATION

PATIENT

PATIENT LAST NAME	FIRST	MIDDLE		TODAY'S DATE
BIRTH DATE MM/DD/YR	SOCIAL SECURITY NUMBER			MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP
HOME PHONE ☐ NONE	CELL PHONE			☐ YES, PERMISSION TO LEAVE MESSAGES ON PHONE
MAILING ADDRESS		CITY	STATE	ZIP CODE
HOME ADDRESS ☐SAME	APT.	CITY	STATE	ZIP CODE
EMAIL ADDRESS:				
EMPLOYER ☐SELF ☐NONE ☐RET	BUSINESS ADDRESS		BUS. PHONE	OCCUPATION
NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU	RELATIONSHIP	PHONE ( )	ADDRESS	
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?				RELATIONSHIP

IF PATIENT IS UNDER AGE 21

FULL TIME STUDENT ☐YES ☐NO	SCHOOL ATTENDING	CITY	GRADE
BOTH PARENTS NAMES			
PARENTS MARITAL STATUS ☐ S ☐ M ☐ W ☐ D ☐ SEP	IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? ☐Mo ☐Fa FINANCIAL CUSTODY? ☐Mo ☐Fa		

FINANCIAL RESPONSIBILITY **IF SELF, CHECK HERE AND SKIP TO NEXT SECTION ☐**

PERSON RESPONSIBLE LAST NAME	FIRST	MIDDLE		RELATIONSHIP
PHONE	SOCIAL SECURITY NUMBER		DRIVER'S LICENSE NUMBER	STATE
HOME ADDRESS ☐SAME AS ABOVE	CITY		STATE	ZIP CODE
EMPLOYER ☐SELF ☐NONE ☐RET	BUSINESS ADDRESS	BUS. PHONE	OCCUPATION	

PRIMARY DENTAL INSURANCE ☐NONE ☐PA, MEDICAID, WELFARE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	

SECONDARY DENTAL INSURANCE ☐NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	