Patient Registration for the office of Lisa A Fagioletti DMD LLC

Welcome! Please bring your insurance card and ID to each dental appointment.

Patient Information

Full Patient Name:_____ Date of Birth:_____

I prefer to be called:_____ Patient's Social Security Number:_____

Driver's License Number:_____Email:_____

Mailing Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____Work: (_____) _____

Previous Dentist:_____ Last Dental Visit:_____

How did you hear about our office:_____

Emergency Contact Name:_____ Number: (_____)_____

Please fill out if someone other than patient:

Full Name of Responsible Party: _____Date of Birth:_____

Relationship to Patient:_____ Contact Number: (_____)_____

Social Security Number:_____ Driver's License Number:_____

Mailing Address:_____

Primary Dental Insurance Information

Primary Dental Insurance Company:_____

Name of Policy Holder:_____ Their Date of Birth:_____

Your relationship to policy holder (please circle): self spouse child other

Policy Holder Social Security Number or Insurance ID Number:_____ Employer:_____

Secondary Dental Insurance (please circle): yes no

Secondary Dental Insurance Company:_____

Name of Policy Holder:_____ Their Date of Birth:_____

Your relationship to policy holder (please circle): self spouse child other

Policy Holder Social Security Number or Insurance ID Number:_____ Employer:_____

Please call the office at your earliest convenience when there are **ANY changes to the information above.**

signature of patient, parent, or legal guardian **date**

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

UPDATED 2018

Patient Data Release and Consent

Many of our patients allow family members such as their spouse, parents or others to call and request information including appointment days and times, results of procedures, etc. Under HIPAA laws, we need your written consent to give this information. IF YOU WISH TO HAVE YOUR PROTECTED HEALTH INFORMATION RELEASED TO INDIVIDUALS YOU HAVE LISTED BELOW, you must fill-in and sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent will remain in force until revoked or requested in writing by you our patient.

I authorize Lisa A. Fagioletti, DMD, LLC to release information about my care including appointment days/ times, results of tests and procedures and billing information to the following individuals:

_____ Relation to patient:_____

_____ Relation to patient:_____

_____ Relation to patient:_____

Authorization to Leave Messages with Household Members and Answering Machine/ Voicemail

It is necessary for representatives of Lisa A Fagioletti, DMD, LLC to leave telephone messages for patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the staff would like to discuss procedure results, or to ask a patient to call our office regarding an issue or concern. The purpose of this consent is to leave messages with members of your household or on your answering machine/ voicemail. We will not discuss your medical circumstances or condition without your consent. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent will remain in force until revoked or requested in writing by you our patient.

Lisa A. Fagioletti, DMD, LLC may leave messages on my home phone number, cell phone number, voice messaging system, text messaging and email. **Please circle yes or no**

Lisa A. Fagioletti, DMD, LLC may leave a message with the individual(s) listed above on this form. **Please circle yes or no**

Patient:_____ Date:_____

Signature of Patient/ Guardian:_____

Financial Responsibility Statement & Insurance Assignment 2018*

For the Office of Lisa A Fagioletti DMD LLC

I authorize the release of dental information to my insurance company for payment to be made. I assign to Lisa A Fagioletti DMD LLC payment of benefits to cover dental expenses.

I understand my insurer may not pay for all services provided by Lisa A Fagioletti DMD LLC. I understand this office may NOT be a participating provider in my insurance plan. I understand it is my responsibility to know the benefits of my insurance plan. Insurance claims will be submitted to my insurance company; however, benefits my insurance plan pays are not guaranteed.

Payment is expected at the time of service. The office will collect the patient's deductible and the ESTIMATED co-pay. After insurance payment is received, the patient will be billed for any difference between the anticipated insurance payment and the actual insurance payment. If the insurance payment is greater than the estimation, we will either refund the amount to the patient or leave the credit balance on the patient's account to be applied toward future treatment.

I understand that I am financially responsible for any balance or charges not covered by my insurance company. I also understand that if my account balance is 90 days overdue, my account will be sent to a collection agency and I will be responsible for all collections fees. A $25 collection fee will be charged to my account in addition to my balance owed.

I understand failure to give 24 hour notice of appointment cancellation will result in a $40 charge. If I have Dominion Dental HMO, it will follow the pre-set "broken appointment" fee on my fee schedule.

I understand there is a $35 charge for any returned check.

If I have insurance that will not reimburse Lisa A Fagioletti DMD LLC directly, payment is expected in full at time of service. If I am an uninsured patient, payment is expected in full at time of service.

I will bring my insurance card to all appointments. If there are any changes in my insurance benefit, I will update that information with Lisa A Fagioletti DMD LLC as soon as possible.

By signing this form as the different Responsible Party*, I am confirming that I am the Responsible Party for, and am financially responsible for, the patient listed below.

_____

Please print patient's name

_____

Signature of patient, parent or legal guardian Date

_____

Signature of different Responsible Party (if someone other than above)* Date

Lisa A Fagioletti DMD LLC

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one)

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement

___ A communication barrier prevented us from obtaining acknowledgement.

___ The individual was unwilling to sign

___ Other

_____ _____
Staff Member Signature Date