Fuschino Family Dentistry

Personal History: (Please Print)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name/Address/Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently undergoing treatment for a medical condition? Y / N

Have you undergone any medical treatment / surgeries within the past 2 years? Y / N

Do you plan on undergoing any medical treatment / surgeries in the near future? Y / N

Do you have a prosthetic joint? (Hip, knee, shoulder) Y / N

Have you undergone any heart surgeries? (Stents, valves) Y / N

Are you currently on any blood thinners? (Not including 81mg Aspirin) Y / N

Are you currently or have you ever taken bisphosphonates (meds for osteoporosis)? Y / N

Do you have a history of radiation therapy directed to the head and neck region? Y / N

Are you currently or have you ever smoked / used tobacco products? Y / N

Are you currently pregnant or anticipating an upcoming pregnancy? Y / N

Are you currently taking birth control medication? Y / N

Do you have any allergies or adverse reactions to the following? (If not included, please write in on the line provided)

 Penicillin: Y / N Clindamycin: Y / N

 Azithromycin: Y / N Latex: Y / N

 Narcotics (hydrocodone, codeine): Y / N

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please List all Medications that are currently Being Taken:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have, have you had, or have you ever been treated for any of the following conditions?

Y / N Arthritis Y / N High / Low Blood Pressure

Y / N Anorexia, Bulimia Y / N Thyroid (hyper or hypo)

Y / N Kidney, Liver disorders Y / N Ulcerations

Y / N Diabetes (If so HbA1c :\_\_\_\_) Y / N Hepatitis, HIV

Y / N Anemia Y / N Asthma

Y / N Diverticulitis, Colitis Y / N Hemophilia (If so which factor: \_\_\_\_)

Y / N Glaucoma Y / N Cancer

Y / N Anxiety/Depression Y / N Shortness of Breath

Y / N Sinus Issues Y / N Epilepsy, Seizures, Fainting Spells

Y / N Chemical Dependency Y / N Migraines

If there is any medical history that you imagine would have an impact upon your dental care please indicate below:

**Dental History:**

Circle which statement would best summarize your dental goals?

*I just don't want to be in pain*

*I want to be able to chew better*

*I want to keep what I have*

*I want to be able to smile*

*I want a beautiful Hollywood smile*

*My spouse/girlfriend/boyfriend brought me here (circle at your own peril)*

**Past Dental History: (**complete only if you are a **NEW** patient**)**

My last dental exam was conducted:

*Over 2 years ago 1-2 Years ago Less than 1 year ago within the last 6 months*

My last dental radiographs were taken:

*Over 2 years ago 1-2 Years ago Less than 1 year ago within the last 6 months*

Name of previous dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number of previous Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail of previous dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Evaluation:**

How many times per day do you brush your teeth?

 *Never Some Days 1x per Day 2x per day 3+ per day*

How many times per week do you floss?

*Floss? Rarely 1-2x per Week 3-4x per Week Every Day 2+ per Day*

How often do you snack / drink throughout the day besides breakfast, lunch, and dinner?

*Never Occasionally I drink/snack often I always have something*

Do you chew gum? Y / N If so how much and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following oral habits?

*Biting fingernails Mouth Breathing Use your teeth to open things Thumb sucking*

Have you ever sustained extra oral trauma to your jaw and/or teeth? Y / N

Do you grind or clench your teeth? Y / N

Have you ever been diagnosed with TMJ / TMD? Y / N

Are your teeth sensitive to hot, cold, sweets, or biting? Y / N

Have you ever been diagnosed with periodontal disease? Y / N

Are you aware of any bumps, swellings, white areas, or discolorations in your mouth? Y / N

Have you ever had braces? Y / N

If there is anything that you feel the doctor should know about prior to receiving dental care that has not been previously listed, please indicate below:

THE INFORMATION GIVEN ABOUT MY HEALTH HISTORY IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE MY CONSENT TO PERFORM NECESSARY DIAGNOSTIC TESTS AND EVALUATION OF MY ORAL HEALTH.

Signature of Patient / Parent or Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fuschino Family Dentistry

Patient Financial Responsibility

Our office is committed to providing you with the best possible care. To achieve this goal and maintain a good patient relationship, it is important that you are aware of your financial responsibility for the treatment provided.

**Patients without dental insurance are required to pay at the time of service.**

**Accepted forms of payment include: cash, check, Master Card, and Visa.**

Patients with insurance coverage are responsible to know their plan benefits. Your insurance policy is a contract between you and your insurance company. Our office is not responsible for how your insurance company processes your claims. Benefit periods, deductibles, co-pays, coordination of benefits, non-covered benefits, alternate benefits and maximums are all factors in determining your benefit. Your concerns regarding insurance coverage should be addressed to your insurance carrier. We ask that you contact them for verification of any of the factors listed above, as they may have definite impact on your benefit. Although, we will make every attempt to assist you in learning about your coverage for services, we cannot assume responsibility for this information. Estimated co-payments are required at time of service. These estimates are based on our charges and may not reflect your actual coverage.

Please read carefully and sign in agreement.

* Payment in full at time of service for non-insured patients.
* Estimated co-pays due at time of service for those insured
* Insured patients are required to know their policy and understand that they are ultimately responsible for all charges incurred
* Pre-estimates are available on request. Keep in mind this is not a guarantee of payment from your insurance company.
* As a courtesy, your insurance company will be billed for all services.

Assignment of Benefits & Release of Medical Information: If payment is not made at time of service, I hereby authorize and request my insurance company to issue payment for all services rendered to me or my dependents directly to Fuschino Family Dentistry. I authorize the release of any medical or other information required to process insurance claims. I hereby assign to Fuschino Family Dentistry, all insurance benefits to which I am entitled. This Assignment will remain in effect until revoked by me in writing.

I understand and agree that all charges for services proved are ultimately my responsibility.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fuschino Family Dentistry

Acknowledgement of receipt of

Notice of Privacy Practices

By signing below, I hereby acknowledge I have received a copy of this office’s Notice of Privacy Practices, and have therefore been advised how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_