Patient Information

Name _____ Date _____
Last, First MI

Address _____
Street Apartment #

_____
City State Zip Code

Phone (Home) _____ (Work) _____ Ext: _____ (Cell) _____
(Please circle preferred number)

Social Security # _____ Birth Date _____ Occupation _____

Marital Status _____ Spouse's Name _____

Emergency Contact _____ Phone _____

Whom may we thank for referring you to our practice? _____

Dental Information – New Patients Only

Date of last dental visit _____ What was done at that time? _____
Date of last dental x-rays _____
Did you ever have a difficult experience associated with dental treatment? ☐ Yes ☐ No
If yes, please explain _____
Describe your current dental concerns _____
How do you feel about the appearance of your teeth? _____

☐ Do your gums bleed?
☐ Do you experience earaches/neck pain?
☐ Are your teeth sensitive to cold/hot/sweets/pressure?
☐ Do you have jaw discomfort or clicking when eating?
☐ Have you had previous orthodontic/periodontal treatment?
☐ Would you like to improve your smile?
☐ Does snoring affect your sleep?

Health Information

Have you ever had any of the following? Please check only those that apply:

☐ Abnormal Bleeding
☐ AIDS
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease _____
☐ Blood Transfusion _____
☐ Cancer/Chemotherapy
☐ Cardiovascular Disease
Type _____
☐ Diabetes Type _____
☐ Dizziness/Fainting
☐ Dry Mouth
☐ Epilepsy
☐ GI Disease
☐ GI Reflux/Heartburn
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Night Sweats
☐ Oral Contraceptives
☐ Osteoporosis
☐ Pacemaker
☐ Persistent Cough
☐ Pregnancy
Due Date _____
☐ Radiation Treatment
☐ Recurrent Infections
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Severe, Rapid Weight Loss
☐ Sexually Transmitted Disease
☐ Sinus Problems
☐ Sleep Disorder
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disorder
☐ Tumors
☐ Codeine Allergy
☐ Latex Allergy
☐ Local Anesthetic Allergy
☐ Penicillin Allergy
☐ Sulfa Allergy
☐ Other Allergies _____
_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain _____
- Name of Physician _____ Phone _____
- List any prescription or over-the-counter medications (including aspirin), vitamins or natural supplements you are taking:
  _____
  _____
- Do you need antibiotic premedication before dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding information provided is accurate and true.

_____ Date _____
Signature of patient, parent or guardian

Insurance Information

Primary

Name of Insured _____ Is Insured a Patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date _____ ID #: _____ Group # _____

Insured's Address _____
Street City State Zip Code

Insured's Employer Name _____

Address _____
Street City State Zip Code

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address _____

_____

Secondary

Name of Insured _____ Is Insured a Patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date _____ ID # _____ Group # _____

Insured's Address _____
Street City State Zip Code

Insured's Employer Name _____

Address _____
Street City State Zip Code

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

In consideration for the professional services rendered to me, at my request, I agree to pay for said services to the Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If there is no activity on an account for 180 days, the account will be sent to collections. Any associated collection fees, in addition to the treatment balance and accrued interest, are the responsibility of the guarantor.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you, or your assignee, to telephone me at home or work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

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

_____ Date _____ Relationship to Patient _____
Signature of guarantor of payment / responsible party

Medical History Update

Date	Comment	Initials

Mario S. Fiorentini DMD PA dba MSF Group

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Peggy Alfonso

732-545-1023

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____