

PATIENT REGISTRATION

ID:Chart ID:

First Name:Last Name:Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible PartyPreferred Name:

Responsible Party ( if someone other than the patient )

First Name:Last Name:Middle Initial:

Address:Address 2:

City, State, Zip:Pager:

Home Phone:Work Phone:Ext:Cellular:

Birth Date:Soc Sec:Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient☐ Primary Insurance Policy Holder☐ Secondary Insurance Policy Holder

Patient Information

Address:Address 2:

City:State / Zip:Pager:

Home Phone:Work Phone:Ext:Cellular:

Sex: ☐ Male ☐ FemaleMarital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date:Age:Soc Sec:Drivers Lic:

E-mail:☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID:Pref. Dentist:

Employer ID:Pref. Pharmacy:

Carrier ID:Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured:Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec:Insured Birth Date:

Employer:

Address:

Address 2:

City, State, Zip:

Rem. Benefits:

Ins. Company:

Address:

Address 2:

City, State, Zip:

Rem. Deduct:

Secondary Insurance Information

Name of Insured:Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec:Insured Birth Date:

Employer:

Address:

Address 2:

City, State, Zip:

Rem. Benefits:

Ins. Company:

Address:

Address 2:

City, State, Zip:

Rem. Deduct:

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

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, please explain: \_\_\_\_\_  
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: \_\_\_\_\_  
Have you ever had a serious head or neck injury? Yes No If yes, please explain: \_\_\_\_\_  
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? Yes No  
Have you ever taken Fosmax, Boniva, Actonel, or other medications containing bisphosphonates? Yes No  
Are you on a special diet? Yes No  
Do you use tobacco? Yes No  
Do you use controlled substances? Yes No  
Do you need to pre-medicate? Yes No If yes, please explain: \_\_\_\_\_  
Have you had any joint replacement surgeries? Yes No  
Have you ever had a skin reaction to metal? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa

Other If yes, please explain: \_\_\_\_\_

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

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain: \_\_\_\_\_

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 \_\_\_\_\_ DATE \_\_\_\_\_

## GIGLIO, DDS & FANELLI, DMD

### HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing the consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- \*Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- \*The practice reserves the right to change the privacy policy as allowed by law.
- \*The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- \*The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- \*The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical/dental condition with any member of your family? YES NO

If YES, please name the members allowed:

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This consent was signed by: \_\_\_\_\_  
(PRINT NAME PLEASE)

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

Date: \_\_\_\_\_

Witness Initials: \_\_\_\_\_

## Appreciated Patient Letter

To Our Appreciated Patient,

Our goal is to consistently improve services and quality of care for you, your family and friends. We will treat you in an efficient and cost effective manner, which will make each visit exceptional. The highest compliment our office can receive is the referral of your friends and family. Our patient directive is outlined below:

- **Insurance:** Treatment recommendations are based on your health, not on your insurance or lack thereof. We expect patients to be aware of their individual benefits. Remember insurance companies are not concerned about your health or wellbeing, we are. As a courtesy, we provide you with an estimate of benefits; however you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company and we will not be responsible for what your insurance will or will not cover.
- **Timeliness:** Our commitment is to see you on time, barring any emergent or unforeseen circumstances. Our expectation is that our patients be on time as well. If you are more than 10 minutes late, you may have to reschedule.
- **Missed Appointments:** It is critical to reschedule missed appointments in order to avoid setbacks in your care. Failure to keep an appointment not only compromises your health, but it also inconveniences other patients who may have requested your reserved time. If you cannot make an appointment, we expect that a 48 business hour notice be given. Failure to do so will result in a \$100 cancellation fee. This fee is not covered by insurance.
- **Finances:** We strive to run a Zero Balance office focusing on Dentistry not Banking/Accounting. In order to achieve this, we require 50% of your total patient out of pocket expense to reserve any scheduled appointment. We have financial options available for all of our patients. Please speak with Deanna, Jamie or Paula if you have any questions regarding financial options.
- **Emergencies:** It is our goal to eliminate all potential dental emergencies based on our treatment philosophy. In the rare instance that you do have an emergency, rest assured that we will take care of you. In the case of swelling, bleeding, severe pain that has kept you up at night or requires medication or a restoration in a visible area that falls out, we ask that you call us right away and we will provide you with the next available emergency appointment. We set aside time daily for these types of emergencies.

Yours in Dental Health,  
Bruno Giglio, DDS

I have read and agree to the terms of the Appreciated Patient Letter.

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(Patient Signature)

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(Patient's Printed Name)

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(Date)

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(Team Signature)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

1. Do you like the way your teeth look? Yes ( ) No ( )

**Explain:** \_\_\_\_\_

2. Are you happy with the color of your teeth? Yes ( ) No ( )

**Explain:** \_\_\_\_\_

3. Would you like for your teeth to be whiter? Yes ( ) No ( )

**Explain:** \_\_\_\_\_

4. Would you like your teeth to be straighter? Yes ( ) No ( )

**Explain:** \_\_\_\_\_

5. Do you have spaces between your teeth that you would like closed?  
Yes ( ) No ( )

**Explain:** \_\_\_\_\_

6. Would you like your teeth to be longer? Yes ( ) No ( )

**Explain:** \_\_\_\_\_

7. Do you like the shape of your teeth? Yes ( ) No ( )

**Explain:** \_\_\_\_\_

8. Do you have missing teeth that you would like replaced? Yes ( ) No ( )

**Explain:** \_\_\_\_\_

9. Do you have old silver fillings that you would like to be replaced with  
tooth-colored fillings? Yes ( ) No ( )

**Explain:** \_\_\_\_\_

10. If you could change anything about your smile, what would you change?  
Yes ( ) No ( )

**Explain:** \_\_\_\_\_