CONIGLIO family dentistry

PATIENT INFORMATION

Patient Name: _____ Preferred Name:_____
Last **First** **MI**

Sex: U M F Marital Status: S M D W Birth Date: _____ SS#: _____

Primary Contact Number: _____ Email Address: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Responsible Party (If Different from Above**):** _____ Relationship: _____ Phone: _____

Who May We Thank for Referring You To Our Office? _____
Circle all that apply: Facebook Page, Group or Ad- Instagram Page or Ad- Google Reviews- Google Ad- Insurance Company- Our Website

PHOTOGRAPHY & SOCIAL MEDIA CONSENT

For News Media, Promotional Materials, Written Articles, Research and/or Photograph

I, _____ (Patient), authorize Coniglio Family Dentistry, to take photographs, and/or videos of my face, jaws, and teeth; before, during and after treatment. I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential, (other than if Full Face photographs are used). I do not expect compensation, financial or otherwise, for the use of these photographs.

I consent to allow the photographs or videos to be used for the following:

☐ Dental records, dental research, dental education including lectures, seminars, demonstrations professional publications such as journals or books.

☐ Social media (Facebook, Instagram, Twitter, Google, Yelp) marketing material including websites and printed materials, patient education FULL FACE/ MOUTH

☐ I refuse to share.

PRIMARY INSURANCE INFORMATION

Dental Insurance Company: _____ Subscriber ID#: _____Group #_____

Insurance Phone # to Verify Benefits: _____ Policy Holder's Name: _____

Relationship to Patient: _____Policy Holder's Employer: _____

Policy Holder's SS# (if ID is not available): _____ DOB: _____

Billing Preference: I prefer statements via **postal mail**: _____ I prefer statements via **email**: _____

APPOINTMENT CANCELLATION POLICY

Your appointment time is reserved exclusively for you. In the event that you need to reschedule or cancel your appointment we require a 24-hour notice. We reserve the right to charge a $50.00 fee to patients who do not provide adequate notice regarding their appointment. This fee cannot be billed to your insurance company.

By signing below, I certify all information provided is true and correct to the best of my knowledge. I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I understand the abovementioned cancellation policy.

Patient/Guardian Signature: _____ Date: _____

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HEALTH HISTORY

Patient Name: _____ Birth Date: _____ Date: _____

Please Note: Any change in your health status should be reported to this office at the earliest possible time.

Check (√) if you ***have*** or ***had*** any history of the following:

AIDS/HIV	☐	Head Injuries	☐	Respiratory Disease	☐
Anemia	☐	Headaches	☐	Rheumatic Fever	☐
Anxiety / Depression	☐	Heart Conditions	☐	Shortness of Breath	☐
Arthritis / Rheumatism	☐	Hepatitis / Type _____	☐	Sinus Trouble	☐
Asthma	☐	Herpes	☐	Special Needs	☐
Back Problems or Surgeries	☐	High Blood Pressure	☐	Stomach Problems	☐
Bisphosphonates Therapy If yes, what type: Oral / IV	☐	Jaundice	☐	Stroke	☐
Blood Disease	☐	Jaw Pain	☐	Swollen Neck Glands	☐
Cancer	☐	Joint Replacement (hip, knee, shoulder)	☐	Thyroid Problems	☐
Chemical Dependency	☐	Kidney Disease	☐	TMJ	☐
Chemotherapy Treatment	☐	Liver Disease	☐	Tobacco Habit	☐
Circulatory Problems	☐	Low Blood Pressure	☐	Tuberculosis	☐
Congenital Heart Disease	☐	Leukemia	☐	Tumors	☐
Cortisone Treatments	☐	Mitral Valve Prolapse	☐	Ulcer	☐
Diabetes / Type _____	☐	Neck Problems or Surgeries	☐		
Epilepsy	☐	Nervous Disorder	☐	***WOMEN:*** Are you pregnant? ☐ No ☐ Yes - Due:_____	
Excessive Bleeding	☐	Pacemaker	☐	Are you nursing? ☐ No ☐ Yes	
Fainting or Dizziness	☐	Psychiatric Care	☐	Taking Birth Control? _____	
Glaucoma	☐	Radiation Treatment	☐		

Any recent hospitalizations/surgeries? ☐ Yes ☐ No

If yes, when and for what? _____

Do you require a premedication/antibiotic for dental treatment? ☐ Yes ☐ No

Preferred Pharmacy: _____

Allergies: ☐ Aspirin ☐ Barbiturates (Sleeping Pills) ☐ Codeine ☐ Iodine ☐ Latex ☐ Penicillin ☐ Local Anesthetic ☐ Sulfa ☐ Other _____

Medications: List any medications you are currently taking and the correlating diagnosis:

_____

_____

TO THE BEST OF MY KNOWLEDGE THE PROCEEDING QUESTIONS HAVE BEEN ACCURATELY ANSWERED.

Signature of Patient/Parent or Guardian _____

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PRE-CLINICAL EXAMINATION QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Reason for today's visit: _____ When was your last dental appointment?_____

What is your primary concern? _____

How often do you floss? _____ How often do you brush? _____

Do you frequently have bad breath?_____ Does food catch between your teeth?_____

Do your gums bleed, feel irritated, tender or swollen? _____

Do you have any pain in your teeth or any part of your mouth because of heat, cold, sweets while biting or chewing?_____
If yes, explain:_____

Do you clench or grind your teeth during the day or have been made aware that you clench or grind at night? _____

Do you ever experience headaches or pain in the side of your face in the area of your ears? _____

Check (√) if you ***have*** or ***had*** any history of the following:

Blisters on lips or mouth	□	Periodontal treatment	□
Burning sensation on tongue	□	Sores or growths in your mouth	□
Cigarette, pipe or cigar smoking	□	Lip or cheek biting	□
Dry Mouth	□	Jaw pain or tiredness	□
Fingernail biting	□	Loose teeth or broken fillings	□
Mouth breathing	□	Orthodontic Treatment	□

Are you embarrassed for other people to see you smile or to see your teeth? _____

If you could change anything about your smile or teeth would it be? NOTHING WHITENESS SHAPE STRAIGHTNESS
OTHER (Explain) _____

When it comes to your oral health which of these is most important to you? Cosmetic, Function, Comfort or Longevity

When considering treatment, would any of these prevent you from moving forward? (i.e. pain, budget, trust or fear)

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Acknowledgement of Notice of Privacy Practices Form

I, _____ (Patient), have been given a copy of this Office's *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that this Office has the right to change this *Notice* at any time.

I am aware that I may obtain a current copy by contacting the Office's HIPAA Compliance Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____	_____	_____
Signature of Patient	Personal Representative (if applicable)	Date

For Facility Use Only: ***Complete this section if you are unable to obtain a signature.***

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

   _____

   _____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement:*

   _____

   _____

_____	_____	_____
Completed By	Signature of Facility Representative	Date