ALBANO & GREENWALD FAMILY DENTISTRY

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Other

Birthdate: ____/____/____ SS#: ____-____-____ Preferred Name: _____

Address: _____
Street Apartment #

_____
City State Zip Code

E-Mail _____ Home# ( )____-____ Work#( )____-____ Ext: _____

Best number to be reached at? ( )____-____ Cell#( )____-____ Other#'s( )____-____

In case of an emergency, whom may we contact?
Name _____ Phone#(___)____-____ Relationship to you _____

Insurance / Employer Information

Primary Insurance
Name of Insured: _____ Birthdate: ____/____/____
Last First MI

ID # or SS#: _____ Group # _____ Employer Name: _____

Insurance Plan Name and Address: _____

_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance
Name of Insured: _____ Birthdate: ____/____/____
Last First MI

ID # or SS#: _____ Group # _____ Employer Name: _____

Insurance Plan Name and Address: _____

_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Financial and Appointment Agreement

You (the patient) will be held **responsible for payment on all dental services** that are provided to you by our office. For those who have dental insurance, any payment that your insurance does not cover you will be held responsible for.

Unpaid balance policy: You will be sent up to three notification letters if balance is left unpaid. The first notice is sent to inform you of your balance with us. The second notification is a reminder and a warning. The third notification is to inform you that we will be sending your unpaid balance to a collection agency and you will be dismissed from our practice.

Hygiene appointments: When you come in for a routine cleaning appointment there may be times a doctor will not be available to perform an exam. If you request an exam by the doctor at each hygiene visit please inform the front desk staff who will mark your account, just be aware that the times and days will be more limited to you when scheduling.

If payment is made by check and the check bounces, then the patient will be subject to a **return check fee of $25.00** in addition to the unpaid balance.

No Show/ Cancellation fee: Our cancellation policy requires you to cancel your appointment within 24 hours or a **"No Show" fee of $75.00** will be applied.
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

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following?

- ☐ AIDS/HIV
- ☐ Artificial Heart Valves
- ☐ Epilepsy
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes-Type 1 or 2
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Mitral Valve Prolapse
- ☐ Kidney Disease
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis-A / B / C
- ☐ High Blood Pressure
- ☐ Thyroid Problems
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Tuberculosis
- ☐ Tobacco use
- ☐ Cold sores
- ☐ Other:

_____
_____
_____

Are you presently taking any <u>MEDICATIONS</u>? If yes, please list.

_____
_____

Are you <u>ALLERGIC</u> to or have had adverse reactions to any of the following?

☐ Penicillin ☐ Erythro ☐ Latex ☐ Codeine ☐ Aspirin ☐ Hay Fever ☐ Sulfa Drugs ☐ Iodine ☐ Local Anestetic
☐ Any other allergies please list.

_____

Have you ever had any of the following?

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Loose teeth
- ☐ Broken fillings

How often do you brush? _____

- ☐ Mouth Breathing
- ☐ Mouth Pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal Treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____

- Are you pregnant or trying to get pregnant? ☐ Yes ☐ No
- Do you require a pre-medication prior to dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- 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: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

ALBANO & GREENWALD FAMILY DENTISTRY

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT)

By signing below I indicate that I have reviewed a copy of Albano & Greenwald Family Dentistry's Notice of Privacy Practices and understand that my signature indicated my consent to use the disclosure of protected health information by Albano & Greenwald Family Dentistry as described in that notice.

_____

Please Print Patient Name

_____

Signature of Patient or Guardian **Date**

ALBANO & GREENWALD FAMILY DENTISTRY

Records Release Request

To: _____
(Doctor/Office Name)

Address: _____

City:_____ State: _____ Zip: _____

Phone: _____ Fax: _____

I authorize the release of dental records relevant to dental treatment, including recent x-rays, or copies of such and request that they be transferred to:

Albano & Greenwald Family Dentistry
146 Highland Ave
Waterbury, CT 06708
Phone: 203-755-7748 Fax: 203-755-7784

****We are a paperless office so please send x-rays by email to****

DrMickandDina@yahoo.com

Patient Name: _____

Date of Birth: _____

_____

Signature (patient, parent, guardian) Date