PATIENT INFORMATION

Patient Name: _____ Gender_____
Social Security #: _____ Date of Birth: _____ Married / Single / Child
Phone (Home): _____ (Cell): _____ (Work): _____
Email Address: _____
Address: _____

HEALTH INFORMATION

1. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. YES / NO Is your general health good?
   If NO, explain: _____
2. YES / NO Has there been a change in your health within the last year?
   If YES, explain: _____
3. YES / NO Have you been in the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. YES / NO Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. YES / NO Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. YES / NO Are you in pain now?
   If YES, explain: _____

2. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle YES or NO)

YES / NO Chest Pain (angina)	YES / NO Fainting Spells	YES / NO Persistent cough
YES / NO Coughing up blood	YES / NO Bleeding problems	YES / NO Frequent urination
YES / NO Headaches	YES / NO Dizziness	YES / NO Blurred vision
YES / NO Bruise easily	YES / NO Frequent vomiting	YES / NO Jaundice
YES / NO Difficulty swallowing	YES / NO Excessive thirst	YES / NO Dry Mouth
YES / NO Shortness of breath	YES / NO Sinus Problems	

Other: _____

3. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle YES or NO)

YES / NO Heart disease	YES / NO AIDS/HIV	YES / NO Psychiatric care
YES / NO Family history of heart disease	YES / NO Osteoporosis	YES / NO Thyroid disease
YES / NO Sexual Transmitted disease	YES / NO Diabetes	YES / NO Asthma
YES / NO Canker or cold sores	YES / NO Tumors or cancer	YES / NO Heart attack
YES / NO Heart Defects	YES / NO Chemotherapy	YES / NO Herpes
YES / NO Heart murmurs	YES / NO Radiation	YES / NO Artificial joints
YES / NO Arthritis, rheumatism	YES / NO Anemia	YES / NO Rheumatic fever
YES / NO Skin Disease	YES / NO Liver disease	YES / NO Eye disease
YES / NO Emphysema or other lung disease	YES / NO Stroke	YES / NO Transplants
YES / NO High blood pressure	YES / NO Tuberculosis	YES / NO Cosmetic Surgery
YES / NO Kidney or bladder disease	YES / NO Seizures	YES / NO Eating disorders
YES / NO Hepatitis A B C		

Other: _____

4. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle YES or NO)

YES / NO	Valium or sedatives	YES / NO	Aspirin	YES / NO	Nitrous oxide
YES / NO	Codeine or other opioids	YES / NO	Latex	YES / NO	Food
YES / NO	Penicillin or other antibiotics	YES / NO	Local anesthetics	YES / NO	Metal

If YES, which ones? _____Other: _____

5. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST 3 MONTHS? (Please circle YES or NO)

YES / NO	Recreational drugs	YES / NO	Tobacco in any form	YES / NO	Antibiotics
YES / NO	Alcohol	YES / NO	Supplements	YES / NO	Aspirin
YES / NO	Weight loss medications	YES / NO	Herbal supplements	YES / NO	Anti-depressants

YES / NO Bisphosphonate (Fosamax) YES / NO Denosumab (Prolia or Xgeva)

YES / NO Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: _____

_____

Please list all prescription medications: _____

6. WOMEN ONLY (Please circle YES or NO)

YES / NO Are you or could you be pregnant? If YES, what month? _____

YES / NO Are you nursing?

YES / NO Are you taking birth control pills?

7. ALL PATIENTS (Please circle YES or NO)

YES / NO Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

YES / NO Have you ever been pre-medicated with antibiotics for dental treatment? (e.g., joint replacement, heart valve replacement, etc.) If YES, why: _____

YES / NO Have you ever taken Fen-Phen? If YES, when: _____

YES / NO **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Physician's Name: _____ Phone Number: _____

Pharmacy: _____ Location: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name: _____ Relationship: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of the form.

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

SPOUSE OR RESPONIBLE PARTY INFORMATION

The following is for : ◯ the patient's spouse ◯ the person responsible for payment
Name: _____ Gender_____
Social Security #: _____ Date of Birth: _____ Married / Single / Child
Phone (Home): _____ (Cell): _____ (Work): _____
Email Address: _____
Address: _____

EMPLOYMENT INFORMATION

Employer Name: _____ Occupation: _____
Address: _____ Phone: _____

INSURANCE INFORMATION

Insurance Company Name: _____ Phone: _____
Insurance Company Address: _____
Member ID #: _____ Group #: _____
Name of Main Subscriber: _____ Date of Birth: _____
Main Subscriber's Address: _____
Main Subscriber Employer Name: _____
Employer Address: _____
Patient's Relationship to Main Subscriber: ◯ Self ◯ Spouse ◯ Child ◯ Other: _____

Secondary

Insurance Company Name: _____ Phone: _____
Insurance Company Address: _____
Member ID #: _____ Group #: _____
Name of Main Subscriber: _____ Date of Birth: _____
Main Subscriber's Address: _____
Main Subscriber Employer Name: _____
Employer Address: _____
Patient's Relationship to Main Subscriber: ◯ Self ◯ Spouse ◯ Child ◯ Other: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made. 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 in full at the time services performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Unpaid balance will be charged directly to the patients credit card on file for all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, with the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if sui be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my 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

PATIENT ACKNOWLEDGMENT OF
RECEIPT OF DENTAL MATERIALS FACT SHEET AND NOTICE OF PRIVACY PRACTICES

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. In addition, the Health Insurance Portability and Accountability Act (HIPPA) requires, effective April 14, 2003, that patients be given a copy of our Notice of Privacy Practice.

If you would, please **PRINT** and **SIGN** your name below,

I, _____, acknowledge I have received from this office a copy of (If you do not want a copy of either sheet, please inform the front desk personnel)

1. Dental Materials Fact Sheet, and
2. Notice of Privacy Practices

_____ _____
Patient or Guardian Signature Date

If signed by a personal representative of the patient, describe the representative's authority to act for the patient.

OFFICE POLICIES

1. **Returned Checks:** There will be a $25 fee for all returned or stopped checks after services are rendered.
2. **Missed/Cancelled Appointments:** A missed appointment or late cancellation fee of $75 per scheduled hour will be assessed for any notice less than 48 business hours. This will be waived 1 time for emergencies only and by Dr. Raffo's discretion.
3. **Pre-Authorization:** Dr. Michael DMD, Inc will submit a pre-authorization for any and all treatment that needs to be completed, but only when requested by the patient. Please understand this will delay treatment for a period of time. We will contact you upon our receipt of the pre determination from your insurance company to schedule necessary treatment.
4. **X-ray Duplication:** We are more than happy to send digital images to other dental specialists per your request. If the receiving office doesn't have digital capabilities, we will provide a printed copy at no charge or a CD for $25.
5. **Insurance Patients:** As a courtesy, we will file your claim for you and allow 30 days for insurance payment to post to your account. On the day of service, we will collect an estimated patient co-payment for the fees charged for the services rendered. Any balance left on the account after the insurance payment is received is the responsibility of the patient or financial guarantor and will be charge to the credit card on file.

I the undersigned, certify that I have read, understand and agree to abide by the above policies.

_____ _____
Patient or Guardian Signature Date

For office use only:
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
◯ Individual refused to sign ◯Communication barriers prohibited obtaining acknowledgment
◯ An emergency situation prevented us from obtaining acknowledgment ◯Other: _____

CREDIT CARD INFORMED CONSENT

PAYMENT AND INSURANCE POLICIES

Due to continual problems dealing with insurance companies for payment on services already rendered, we are informing you that we find it necessary to make changes regarding the use of dental insurance in our practice.

It has always been our intent to help our patients bill their insurance companies. We will continue this policy, but will bill your insurance company only **ONCE.** Because there are so many different insurance companies with different deductibles and eligibility requirements, it is impossible to know what money may still be owed for completed services after insurance payments have been received. Consequently, our office spends a great deal of time trying to collect payment for completed services not paid by insurances.

To eliminate this problem, we have initiated the following steps:

PATIENTS WITH DENTAL INSURANCE

1. We will bill your insurance once for services rendered.
2. We require a credit card authorization form to be kept in a secure site in your file. This will allow any remaining balance after insurance pays to be charged to the credit card. A receipt will be sent to you. If an insurance company does not respond within four (4) weeks, the balance will be charged to the credit card.

PATIENTS WITHOUT DENTAL INSURANCE

1. Payment in full with be due at the time that services are rendered. For your convenience we accept cash, checks, and all major credit cards.

MISSED/CANCELLED APPOINTMENTS

1. Should you cancel an appointment within 48 hours or simply do not show to a confirmed appointment our $75 cancellation fee will automatically be charged to the credit card on file.

Statements will no longer be sent. This procedure requires a great deal of time, effort and money. We thank you in advance for cooperating with our new policies and we look forward to focusing our efforts on providing the best possible dental care for our patients.

Michael J. Raffo, D.M.D., Inc, Staff & Associates

Name (as it appears on the card): _____

Credit Card #_____Expiration Date: _____

Billing Zip Code: _____

Signature: _____ Date: _____