Welcome to our Practice!

PATIENT INFORMATION:

E-Mail Address	Last Name	First Name
Preferred to be called	Street Address	
City, State, Zip	Date of Birth	
Cell Phone	Work Phone	Home Phone
SS#	Driver's License	Sex (M/F)
Employer	Address, City, State, Zip	
Occupation	Emergency Contact Name	Phone #
Spouse's Name	Occupation	
Spouse's Address (if different than above)	City, State, Zip	

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone #	Place	Time

How did you hear about our office?

Please check: _____ Internet _____ Patient referral _____Website _____Post Card Mailer _____ Radio _____ Newsletter

_____Open House _____Other (Please tell us)_____

If you were referred, whom may we thank for their trust in us?_____

INSURANCE INFORMATION:

Primary Insurance Company	Address	
City, State, Zip	Phone #	
Policy Holder Name	Member's ID#	Date of Birth
Group # or Policy #		
Secondary Insurance Company	Policy Holder Name	Date of Birth
Group # or Policy #		

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement, directly to Michael A. Petrillo, DMD, PC of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date:_____ Patient's Signature: _____

CONSENT:

I hereby authorize Lehigh Valley Smile Designs to take the necessary X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Lehigh Valley Smile Designs to make a thorough diagnosis of the patient's dental needs. I also authorize Lehigh Valley Smile Designs to perform all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier and not between Michael A. Petrillo, DMD PC and your insurance company I fully understand that it is my responsibility entirely for all dental treatment regardless of insurance coverage.

Date:_____ Patient's Signature: _____

HIPAA PRIVACY FORM
Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

Patient Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] No information is to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call

[ ] my home phone _____

[ ] my work number _____ [ ] my cell number _____

If unable to reach me :

[ ] you may leave a detailed message [ ] please leave me a message asking for a return call

The best time to reach me personally is (day) _____ between (time) _____

Signed: _____ Date: ____/____/_____

Our Financial Philosophy

It is important to us that the quality of our business services matches the quality of our dental care. We want the handling of your account, from the start to be perceived as an extension of the dental care we provide you and your family.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of services. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

So that we may file your insurance claim(s) correctly, we ask all patients to complete our Information and Insurance Form before seeing the doctor as that insures our office of obtaining the correct information to better serve you in regards to your benefits.

Regarding Insurance

Daily we electronically file insurance claims for all patients with insurance benefits. We can accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

WE ACCEPT CASH, CHECKS OR MASTERCARD, VISA, AMERICAN EXPRESS and DISCOVER. Ask us about LAY AWAY OPTIONS or financial services with CARE CREDIT or CITI HEALTH CARD. WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL which which I give my consent for a credit check.

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Michael A. Petrillo, DMD PC must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by Michael A. Petrillo, DMD PC. I give consent for any credit check to be completed by Michael A. Petrillo DMD PC should it be deemed necessary.**

I have the read the Financial Philosophy. I understand, accept and agree to this Financial Philosophy.

_____ _____ _____ _____

Signature of Patient or Responsible Party Date Witness for Lehigh Valley Smile Designs Date

MEDICAL HEALTH HISTORY

PATIENT NAME: _____ **Date:** _____

Person Completing Form: _____Relationship_____

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year? Explain: _____
3. Yes No Have you been hospitalized, had a serious illness or operation in the past 5 years? _____

_____

4. Yes No Are you being treated by a physician now? For what? _____

Primary Physician:_____Phone_____City & State_____

Date of last physical examination:_____Date of last blood test/work up:_____

Other Physicians & Specialists

Name:_____Speciality_____Phone_____City_____

Name:_____Speciality_____Phone_____City_____

B. HAVE YOU EVER EXPERIENCED?

5. Yes No Bleeding Problems
6. Yes No Blurred Vision
7. Yes No Chest Pains
8. Yes No Difficulty Swallowing
9. Yes No Dizziness
10. Yes No Dry Mouth
11. Yes No Excessive Thirst
12. Yes No Fainting Spells
13. Yes No Frequent Headaches
14. Yes No Frequent Urination
15. Yes No History of Diabetes, Heart Problems, Cancer
16. Yes No Jaundice
17. Yes No Joint Pain, Stiffness
18. Yes No Mouth Ulcers
19. Yes No Persistent Cough, Coughing up Blood
20. Yes No Recent Weight Loss, Fever, Night Sweats
21. Yes No Ringing in Ear
22. Yes No Seizures
23. Yes No Shortness of Breath
24. Yes No Sinus Problems
25. Yes No Sleep Apnea or Chronic Snoring
26. Yes No Wound or Sore that bleeds easily or does not heal

C. DO YOU HAVE OR HAVE YOU HAD:

27. Yes No Anemia
28. Yes No Angina
29. Yes No Anxiety
30. Yes No Arthritis, Rheumatism
31. Yes No Artificial Joint or Prosthesis
32. Yes No Asthma
33. Yes No Cancer: Type_____ Yr. Dx_____
34. Yes No Congenital Heart Defects
35. Yes No Congestive Heart Failure
36. Yes No Coronary Heart Disease
37. Yes No Diabetes
38. Yes No Epilepsy or other Seizure Problems
39. Yes No Gerd, Gastro-Esophageal Reflux Disease
40. Yes No Glaucoma or any other Eye Disease
41. Yes No Hay Fever, Skin or Food Allergies or allergies in general
42. Yes No Heart Attack: Date_____
43. Yes No Heart Murmur
44. Yes No Heart Valve(s) Damage/Mitral Valve Prolapse
45. Yes No Hemophilia or other Bleeding Disorders
46. Yes No Hepatitis A B C
47. Yes No Herpes
48. Yes No High Blood Pressure
49. Yes No Immune Disorders-Lupus, HIV, AIDS-ARC
50. Yes No Infective Endocarditis
51. Yes No Kidney, Bladder Diseases
52. Yes No Measles
53. Yes No Mental Health Issues
54. Yes No Mumps
55. Yes No Psychiatric Condition:
    Yes No Under Treatment Now?
56. Yes No Rheumatic Fever
57. Yes No Scarlet Fever
58. Yes No Sexually Transmitted Disease (STD)
59. Yes No Skin Problems
60. Yes No Sinus Problems
61. Yes No Stroke: Date_____
62. Yes No Tonsillitis
63. Yes No TB, Emphysema or Lung Disorder
64. Yes No Ulcers, Acid Reflux, or Stomach Problems
65. Yes No VD (syphilis or gonorrhea)

D. DO YOU HAVE OR HAVE YOU HAD:

67. Yes No Artificial Joint_____Date:_____
68. Yes No Blood Transfusions _____
69. Yes No Chemotherapy _____
70. Yes No Contact Lenses _____
71. Yes No Currently taking Birth Control Pills_____
72. Yes No Currently Pregnant or nursing _____
73. Yes No Organ Transplant: Organ_____
74. Yes No Pacemaker
75. Yes No Prosthetic heart valve
76. Yes No Psychiatric Care
77. Yes No Radiation Treatments

E. DO YOU TAKE OR HAVE TAKEN:

78. Yes No Alcohol: How often: ____Daily _____Weekly _____Sometimes
79. Yes No Fosamax/Boniva or other Biphosphonate drugs
80. Yes No Phen Phen diet Pills or any other diet pills
81. Yes No Recreational Drugs: Any Rehab? Yes No Dates:_____
82. Yes No Tobacco in any form? Type_____ Quantity_____ Date Started_____

F. MEDICATIONS

a. Are you taking ANY drugs, medications or treatments at this time?

List Prescription Medications: _____

_____

_____

List Over The Counter Medications (such as Aspirin, Advil, Allergy, sleeping aids, etc.):

List Vitamins and Supplements:

G. ALLERGIES

a. **Are you allergic to:**

83. Yes No Acrylics
84. Yes No Dental Anesthesia (local)
85. Yes No Fluoride
86. Yes No Foods: List_____
87. Yes No Gluten
88. Yes No Latex
89. Yes No Metals or Jewelry
90. Yes No Spices, Flavorings or Colorings: List_____

b. Have you had an allergic reaction or unusual response to ANY medications, drugs, pills or treatments, etc.

91. Yes No Please list allergies:_____

_____

ALL PATIENTS:

92. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

93. Yes No Have you ever been told by a physician or dentist that you need to pre-medicate prior to any dental treatment?

Certify and Consent:

I certify that all the preceding information is correct and if there is ever any change in health, or medication, this practice will be informed of the change(s) without fail. I consent to allow the practice to contact any healthcare provider(s) and to have the patient's health information released to aid in the care and treatment I also consent to allow diagnosis, proper health care and treatment to be performed by Lehigh Valley Smile Designs for the below named individual until further notice.

Signature_____**DATE**

Signature_____**DATE**

(parent or guardian if patient is a minor)

DENTAL HEALTH HISTORY

H. Name of your Former Dentist: _____ How long since you were last seen? _____

94. Is keeping your teeth important to you? [Y] [N] If yes, why? _____

95. On a scale of 1-10, 10 being the best, where would you rate your smile?

96. On a scale of 1-10, 10 being the best, where would you rate your oral health?

97. Have you experienced any of the following problems:

Bleeding gums [Y] [N]
Bad Breath or sour taste in mouth [Y] [N]
Burning sensations in mouth [Y] [N]
Soreness in jaw [Y] [N]
Is it hard for you to open wide [Y] [N]
Clicking or popping in jaw [Y] [N]
Have you or your parents suffer(ed) from Gum Disease [Y] [N]
Did you ever wear braces [Y] [N]
Oral Surgery of any kind [Y] [N]
Sensitivity to Hot & Cold [Y] [N]
Snoring [Y] [N]
Food catching between teeth [Y] [N]
Clenching or grinding of teeth [Y] [N]
Pain/soreness around ears, eyes, face [Y] [N]
Stiff neck muscles [Y] [N]
Do you or your parents wear dentures/partials [Y] [N]
Ever been injured in your mouth or head [Y] [N]
Do you smoke or chew tobacco [Y] [N]

98. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? _____

_____

99. Is the brightness of your teeth important to you? [Y] [N]

100. If you could change anything about your smile which of the following would you want?

Whiter [Y] [N]
Replace missing teeth [Y] [N]
Remove Stains/Spots on teeth [Y] [N]
Straighter [Y] [N]
Close space or spaces [Y] [N]
Replace old crowns [Y] [N]
Excess showing of Teeth [Y] [N]
Less Gum showing [Y] [N]
Show more teeth [Y] [N]
Repair or replace chipped teeth [Y] [N]
Remove mercury silver fillings [Y] [N]
Replace old colored filling(s) [Y] [N]
Reshape/resize my teeth [Y] [N]

101. Fill in this question for us please: Together, what goals would you like for your oral health lifetime care?

102. Please circle the following which are important to you when making your dental health decision.

Convenience
Finances
What insurance covers
Fear or Anxiety
Appearance
Time
Health
Comfort
Relationship with Dental Team
Quality of care
Detailed treatment explanations
Technology

Patient Signature: _____ Date: _____