Dr. Dan Passidomo

Patient's First, Teeth Second!

Welcome to our Practice!

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial _____

E-mail Address: _____

Preferred to be called: _____ Street Address: _____

City, State, Zip: _____ Sex: __M __F Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SS#: _____ Marital Status: __S __M __D __Other Occupation: _____

Employer: _____ Address, City, State, Zip _____

Emergency Contact Name: _____ Phone # _____

Spouse's Name: _____ Occupation: _____

Spouse's Address (if different than above): _____, City, State, Zip: _____

Spouse's Employer: _____ Address, 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 number: _____ Place_____ Time: _____

How did you hear about our office? Please check: _____Internet ____Patient referral ____Website ____Yellow Pages ___Mailer Other _____

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# _____ Birth date: _____

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 the purpose of facilitating the billing and reimbursement, directly to Dr. Dan Passidomo 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 Dr. Dan Passidomo to take the necessary X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Dan Passidomo to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Dan Passidomo to perform any and 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 Dr. Dan Passidomo and your insurance company. I fully understand that it is my responsibility only for all dental treatment regardless of insurance coverage.

Patient Signature: _____ Date: _____

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****

I, _____, have received a copy/explanation of this office's Notice of Privacy Practices.

_____ (Date}_____
(Signature of Patient and/or Guardian)

(Relationship to Patient) Self or Other: _____

☐ I authorize my spouse to receive financial and clinical information.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers (such as a language barrier) prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement at time of service
- ☐ Other (Please specify) _____

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

We file insurance claims for all patients with insurance benefits. We accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. 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 very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 45 **days.**

WE ACCEPT CASH, CHECK, MASTERCARD, VISA and DISCOVER. Ask us about EASY PAY OPTIONS.
WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL 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 Dr. Dan Passidomo must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by Dr. Dan Passidomo. I give consent for any credit check to be completed by Dr. Dan Passidomo should it be deemed necessary.**

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

_____ _____ _____ _____
Signature of Patient or Responsible Party Date Witness for Dr. Passidomo Date

DATE _____

PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Purpose of Appointment _____ Date of last medical exam _____

Have you been in the hospital in the last five years? Yes or No If yes, why? _____

Please check any of the following that apply to you:

AIDS/HIV	☐Yes ☐No	Fainting	☐Yes ☐No	Nervousness/Depression	☐Yes ☐No
Allergies (Seasonal)	☐Yes ☐No	Glaucoma	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Anemia	☐Yes ☐No	Heart Conditions	☐Yes ☐No	Pacemaker	☐Yes ☐No
Arthritis	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Phen Fen (1 month+)	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Heart Surgery	☐Yes ☐No	Radiation (Head/Neck)	☐Yes ☐No
Abnormal Heart Condition	☐Yes ☐No	Hepatitis A	☐Yes ☐No	Respiratory Problems	☐Yes ☐No
Asthma	☐Yes ☐No	Hepatitis B	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Blood Disease	☐Yes ☐No	Hepatitis C	☐Yes ☐No	Rheumatism	☐Yes ☐No
Bruise Easily	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Cancer	☐Yes ☐No	Hip or Joint Replacement	☐Yes ☐No	Seizures	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Jaundice	☐Yes ☐No	Stomach Problems	☐Yes ☐No
Diabetes	☐Yes ☐No	Jaw Joint Pain	☐Yes ☐No	Stroke	☐Yes ☐No
Dizziness	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Drug Addiction	☐Yes ☐No	Knee Replacement	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Emphysema	☐Yes ☐No	Liver Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Epilepsy/Seizures	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Excessive Bleeding	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Other	_____

For Women Only: ☐ Birth Control, ☐ Breast Feeding, ☐ Pregnant ~ 1-3 months, 3-6 months, 6-9 months

Are you currently taking any of the following?

Fosamax	☐Yes ☐No	Actonal	☐Yes ☐No	IV Aredia	☐Yes ☐No
Boniva	☐Yes ☐No	IV Zometa	☐Yes ☐No		

Do you have any of the following drug allergies?

Aspirin	☐Yes ☐No	Latex	☐Yes ☐No	Penicillin	☐Yes ☐No
Darvon	☐Yes ☐No	Local Anesthetic	☐Yes ☐No	Percodan	☐Yes ☐No
Erythromycin	☐Yes ☐No	Nitrous Oxide	☐Yes ☐No	Valium	☐Yes ☐No

Any Other Allergies? _____

Do you take Vitamin Supplements? If so, which ones? _____

Do you need to be pre-medicated before any dental treatment? ☐Yes ☐No If so, what medication? _____

Please answer the following:

Are you having or have you ever had radiation treatment? ☐Yes ☐No

Do you have or ever had Cancer? ☐Yes ☐No If so, what kind? _____

Do you smoke or use smokeless tobacco? ☐Yes ☐No

Are you taking any medications? ☐Yes ☐No

If so, what kind? _____

Other Physical Condition(s)?

_____

Blood Pressure (If known) _____ / _____

Name of Physician _____ Phone # _____

Are you under the care of a physician now? ☐Yes ☐No If so, nature of care? _____

Signature of Person completing Health History? _____

Relationship to Patient_____

DENTAL HEALTH HISTORY

Name of your Former Dentist: _____How long since you were last seen? _____

Why did you leave your former dentist? _____

Please check any of the following that apply to you:

- ☐ Sensitivity (hot, cold, sweet), If so, where? UR, LR, UL, LL
- ☐ Headaches, earaches, neck pain
- ☐ Grinding or clenching teeth
- ☐ Loose, tipped or shifting teeth
- ☐ Is it hard for you to open wide
- ☐ Have you or your parents suffer(ed) from gum disease
- ☐ Oral surgery of any kind
- ☐ Food catching between teeth
- ☐ Do you or your parents wear dentures or partials
- ☐ Do you smoke or chew tobacco
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Bleeding, swollen or irritated gums
- ☐ Bad breath
- ☐ Clicking or popping in jaw
- ☐ Did you ever wear braces
- ☐ Snoring
- ☐ Pain/soreness around ears, eyes, face
- ☐ Ever been injured in your mouth or head

Is keeping your teeth important to you? ☐Yes ☐No If yes, why? _____

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

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

On a scale of 1-10, 10 being the best, how important is your dental health to you? _____

Does having dental treatment make you afraid or nervous? ☐Yes ☐No If yes, what specific thing(s) bother you? _____

_____

Is the brightness of your teeth important to you? ☐Yes ☐No

If you could change anything about your smile, which of the following would you want? (Check all that apply):

Whiter	☐Yes	☐No	Repair chipped teeth	☐Yes	☐No	Replace old crowns	☐Yes	☐No
Straighter	☐Yes	☐No	Replace missing teeth	☐Yes	☐No	Smile makeover	☐Yes	☐No
Close spaces	☐Yes	☐No	Remove stains/spots	☐Yes	☐No	Replace plastic fillings	☐Yes	☐No
Replace silver filings w/tooth colored fillings	☐Yes	☐No	Less gum showing	☐Yes	☐No	Excess showing of teeth	☐Yes	☐No

Where do you see your overall oral health and/or your smile in the next 5 to 10 years? _____

_____

Please circle the following which are important to you when making your dental health decision. (All that apply)

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

What do you do for a living? _____

Cancelled Appointment Policy: We ask that you give 1 business day notice for cancelled and rescheduled appointments. This allows us to serve other patients that may need the appointment. Please be aware that we do charge a fee starting with the 2nd missed appointment.

Patient Signature: _____ Date: _____