Fiastro Dental

PATIENT REGISTRATION

PERSONAL INFORMATION

Patient Name : _____
First *Last* *Middle Initial*

Date Of Birth : ____/____/____ **Gender** : ☐ Male ☐ Female

Address : _____

Phone Number : _____ **E-Mail** : _____

SSN : _____ **Occupation** : _____

Status : ☐ Single ☐ Married ☐ Divorce ☐ Widowed ☐ Other:

How did you hear about us? ☐ Insurance ☐ Online ☐ I live/ work in the area ☐ I was referred by _____

Responsible Party if someone other than the patient

Name *(if not the patient)* : _____

Address *(if different than above)* : _____

EMERGENCY CONTACT DETAILS

Contact Name : _____ **Mobile Number** : _____

Relationship : _____ **Home Number** : _____

INSURANCE INFORMATION

☐ ***No Insurance*** ☐ ***Primary Insurance*** ☐ ***Dental Discount Plan***

Name of Insurance Company : _____ **Phone #:** _____

Policy Holder Name: _____ **Birth Date:** _____

Member ID: _____ **Group #:** _____

Name of Employer: _____

Relationship to Insurance holder: ◯ **Self** ◯ **Parent** ◯ **Child** ◯ **Spouse** ◯ **Other** _____

☐ ***Secondary Insurance***

Name of Insurance Company : _____ **Phone #:** _____

Policy Holder Name: _____ **Birth Date:** _____

Member ID: _____ **Group #:** _____

Name of Employer: _____

Relationship to Insurance holder: ◯ **Self** ◯ **Parent** ◯ **Child** ◯ **Spouse** ◯ **Other** _____

PT #

Fiastro Dental

MEDICAL AND DENTAL HISTORY

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ___ Yes ___ No If yes, : _____
Have you ever been hospitalized or had a major operation? ___ Yes ___ No If yes, : _____
Have you ever had a serious head or neck injury? ___ Yes ___ No If yes, : _____
Are you taking any medications, pills, or drugs? ___ Yes ___ No If yes, please list down : _____
_____
Do you take, or have you taken, Phen-Fen or Redux? ___ Yes ___ No If yes, : _____
Have you ever taken Fosamax, Boniva, Actonel or any ___ Yes ___ No If yes, : _____
Other medications containing bisphosphonates? ___ Yes ___ No If yes, : _____
Are you on a special diet? ___ Yes ___ No
Do you use tobacco? ___ Yes ___ No
Do you use controlled substances? ___ Yes ___ No

FOR WOMEN:

Are you Pregnant/Trying to get pregnant? ___ Yes ___ No Taking oral contraceptives?___ Yes ___ No Nursing? __Yes__ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING

☐ Aspirin ☐ Penicilin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Latex ☐ Sulfa
Other: _____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

__Yes__No AIDS/HIV Positive
__Yes__No Alzheimer's Disease
__Yes__No Anaphylaxis
__Yes__No Anemia
__Yes__No Angina
__Yes__No Arthritis/Gout
__Yes__No Artificial Heart Valve
__Yes__No Artificial Joint
__Yes__No Asthma
__Yes__No Blood Disease
__Yes__No Blood Transfusion
__Yes__No Breathing Problem
__Yes__No Bruise Easily
__Yes__No Cancer
__Yes__No Chemotherapy
__Yes__No Chest Pains
__Yes__No Cold Sores/ Fever Blisters
__Yes__No Congenital Heart Disorder
__Yes__No Convulsions
__Yes__No Cortisone Medicine
__Yes__No Diabetes
__Yes__No Drug Addiction
__Yes__No Easily Winded
__Yes__No Emphysema
__Yes__No Epilepsy or Seizures
__Yes__No Excessive Bleeding
__Yes__No Excessive Thirst
__Yes__No Fainting Spells/ Dizziness
__Yes__No Frequent Cough
__Yes__No Frequent Diarrhea
__Yes__No Frequent Headaches
__Yes__No Genital Herpes
__Yes__No Glaucoma
__Yes__No Hay Fever
__Yes__No Heart Attack/ Failure
__Yes__No Heart Murmur
__Yes__No Heart Pacemaker
__Yes__No Heart Trouble Disease
__Yes__No Hemophillia
__Yes__No Hepatitis A
__Yes__No Hepatitis B
__Yes__No Herpes
__Yes__No High Blood Pressure
__Yes__No Hives or Rash
__Yes__No Hypoglycemia
__Yes__No Irregular Heartbeat
__Yes__No Kidney Problems
__Yes__No Leukemia
__Yes__No Liver Disease
__Yes__No Low Blood Pressure
__Yes__No Lung Disease
__Yes__No Mitral Valve Prolapse
__Yes__No Osteoporosis
__Yes__No Pain in Jaw Joints
__Yes__No Parathyroid Disease
__Yes__No Psychiatric Care
__Yes__No Radiation Treatments
__Yes__No Recent Weight Loss
__Yes__No Renal Dialysis
__Yes__No Rheumatic Fever
__Yes__No Rheumatism
__Yes__No Scarlet Fever
__Yes__No Shingles
__Yes__No Sickle Cell Disease
__Yes__No Sinus Trouble
__Yes__No Spina Bifida
__Yes__No Stomach/ Intestine Disease
__Yes__No Stroke
__Yes__No Swelling of Limbs
__Yes__No Thyroid Disease
__Yes__No Tonsillitis
__Yes__No Tuberculosis
__Yes__No Tumors or Growths
__Yes__No Ulcers
__Yes__No Venereal Disease
__Yes__No Yellow Jaundice

Have you had any other serious illness not listed above? ___ Yes ___ No if yes, _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____
Signature of Patient, Parent or Guardian Date

PT #

DENTAL AND MEDICAL HISTORY

Fiastro Dental

DENTAL HISTORY

Name of Previous Dentist: _____ **Date of last exam** _____

Location of Previous Dentist: _____ **Date of last cleaning** _____

How often do you brush your teeth? _____ **How often do you floss?** _____

Are you feeling any pain right now? If yes please explain: _____

What is the reason for your visit? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS

1. **Are you fearful of dental treatment? How fearful from scale of 1(least) to 10(most)_____** **__Yes__No**
2. **Do your gums bleed while brushing or flossing? ..... __Yes__No**
3. **Are your teeth sensitive to hot or cold liquid/ food?..... __Yes__No**
4. **Are your teeth sensitive to sweet or sour liquid/food?..... __Yes__No**
5. **Do you feel pain to any of your teeth?..... __Yes__No**
6. **Do you have any sores or lumps in or near your mouth?..... __Yes__No**
7. **Do you have any history of periodontal therapy?..... __Yes__No**
8. **Do you like your smile?..... __Yes__No**
9. **Do you snore or have you been told you snore?..... __Yes__No**
10. **Have you ever received oral hygiene instructions?..... __Yes__No**
11. **Have you had any head, neck or jaw injuries?..... __Yes__No**
12. **Do you bite your lips or cheeks frequently?..... __Yes__No**
13. **Have you ever had difficult extractions in the past?..... __Yes__No**
14. **Have you ever had any orthodontic treatment?..... __Yes__No**
15. **Have you ever had any prolonged bleeding during an extraction?..... __Yes__No**
16. **Do you wear partial/full dentures?..... __Yes__No**
17. **Do you wear a Night Guard/ retainers?..... __Yes__No**
18. **Do you have frequent headaches?..... __Yes__No**
19. **Do you clench or grind your teeth?..... __Yes__No**
20. **Have you ever experienced any of the following problems in your jaw?**
    - **Clicking/ popping..... __Yes__No**
    - **Pain (joint, ear, side of face)..... __Yes__No**
    - **Difficulty in opening/ closing..... __Yes__No**
    - **Difficulty in chewing..... __Yes__No**

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent or Guardian **Date**

PT #

Fiastro Dental

CONSENT FOR TREATMENT

I hereby authorize Doctor Fiastro and/or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of _____'s dental needs.	***Initials***
Upon a diagnosis, I authorize the doctor to perform all recommended treatments mutually agreed upon by myself and to employ such assistance as required to provide proper care.	
I agree to the use of anesthetics, sedatives, and other medications necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.	
I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payments are due during service unless other arrangements have been made. If payments are not received by the agreed-upon date(s), I understand that a late fee will be added to my account. Initials	

FINANCIAL POLICIES

Monthly Statements and Patient Balances ***Initials***

Should you have a balance due on your account, we will send you a monthly statement that shows any previous and/or current balances, payments, and/or credits applied to your account, and any additional fees, if applicable. All account balances are due as indicated on your statement unless otherwise agreed upon with the office.	
Should your account become in default by 60 days it will be placed on hold until satisfactory payment and/or payment arrangements have been made with our office. Should your account become in default by 90 days, it may be turned over to our third party collection agency, in which case you may be assessed a $25 fee for this service. Accounts that have been turned over to our third party collection agency are subject to dismissal from our practice with 30-days notice.	

Returned Checks ***Initials***

All checks returned by the bank are charged a $35 return check fee, which will be added to your account.	

Missed appointments ***Initials***

We require 24-hour notice to cancel scheduled appointments. Without proper notice, a fee of $50 will be added to your account.	

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payments are due during service unless other arrangements have been made. If payments are not received by the agreed-upon date(s), I understand that a late fee will be added to my account.

_____ _____

Signature of Patient, Parent, Guardian or Responsible Party **Date**

PT #

Fiastro Dental

Acknowledgment of Review of Notice of Privacy Practices

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I, _____ have reviewed a copy of this office's Privacy Practices.

_____

Print Patient Name/Responsible Party

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of the review of our Notice of Privacy Practices, but we could not obtain for the following reason(s)

- ☐ The individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgment.
- ☐ An emergency prevented us from obtaining the acknowledgement.
- ☐ Other: please specify

_____

_____

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