Patient Registration and Medical/Dental History Form

Niles Family Dentistry Associates Inc
A. Scott Santucci, DMD

Patient Name: (First) __________________ (Middle)______ (Last) ___________________

Date of Birth: __ __/__ __ /__ __ __ __   Age:_______   ☐ Male ☐ Female

Address:

____

(Number) (Street) (City/town) (State) (Zip Code)

Home Phone # : (__ __ __) __ __ __ - __ __ __ __ Cell # (__ __ __) __ __ __ - __ __ __ __

Emergency Contact Name and Phone #____

Social Security Number __ __ __ -__ __- __ __ __ __   Driver's License/ID # __________________________

Employer:____________________________ Spouse Name (if applicable):______________________________

Any immediate family members that are current patients at our office? ___________________________________

Health Information:

1. Are you taking any medication now? ☐ YES ☐ NO

If yes, **please list both prescribed and over the counter medications that you take in the space below**:

1	5
2	6
3	7
4	8

2. Has a dentist or physician ever told you that you need to take antibiotics (penicillin) before having dental treatment due to a joint replacement or heart condition, etc ? ☐ YES ☐ NO

3. Please check any illnesses or conditions you have EVER had:

☐ Drug treatment with Suboxone or Methodone	☐ *Currently* Pregnant/Nursing If Yes, Name of OB/GYN:	☐ Pain Management/taking pain medication from another doctor
☐ Osteoporosis	☐ Epilepsy/Seizures	☐ Heart Attack/Failure
☐ Anemia or blood problems	☐ Kidney or Liver disease	☐ Sinus problems
☐ Any Heart Problems	☐ Heart Murmur	☐ Stroke
☐ Arthritis	☐ Hepatitis A, B, C	☐ Thyroid Problems
☐ Artificial Joint circle: hip/knee	☐ High Blood Pressure	☐ Tuberculosis
☐ Asthma/Breathing problems	☐ Immune system, HIV, AIDS, ARC	☐ Stomach/intestinal disease/reflux
☐ Cancer or Chemotherapy	☐ Kidney problems	☐ Use of tobacco, cigarettes, chew
☐ Diabetes: circle Type 1 or Type 2	☐ Liver problems	☐ Sexually Transmitted Disease
☐ Drug/Alcohol Addiction	☐ Psychiatric care/emotional problems	☐ Use of Wheelchair

4. Do you have any other health conditions? ☐ YES ☐ NO

If yes, please list.____

5. Do you have any **ALLERGIES**? ***If yes***, please check all that apply: ☐ YES ☐ NO

☐ Penicillin ☐ Codeine ☐ Anesthetics ☐ Sulfa drugs ☐ Aspirin ☐ Narcotics ☐ Latex ☐ Metals
☐Other: ____

Name of Physician:___________________________________ Phone:_________________________________

Dental History:

When did you last see your dentist? ___________________ Last Dental Cleaning:______________________

Do you wear Partials or Dentures? _____________________ Jaw Pain/Clenching/Grinding? ________________

6. What do you do to take care of your teeth and gums?
☐ Daily tooth brushing ☐ Daily flossing ☐ Inter-dental stimulators ☐ Water jet device

7. Do you have any pain in your mouth today? ☐ YES ☐ NO

8. Do you have **DENTAL INSURANCE**? ☐ YES ☐ NO

You must provide a copy of your dental insurance card if your insurance company provides one and a photo ID

Insurance Co Name:____________________________ Name of Subscriber:________________________________

Subscriber's Employer:_________________________ Subscriber's S.S #: __ __ __/__ __/__ __ __ __

Subscriber's Date of Birth: ___/___/________ Policy ID #__________________ Group #______________

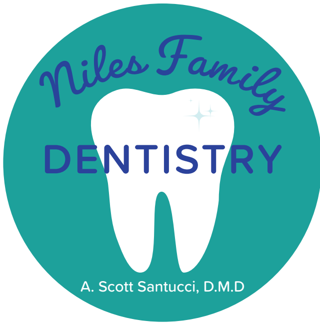
I authorize that this above information is true and correct to the best of my knowledge.

I understand that the dental provider Niles Family Dentistry, may use my health information for treatment, payment and health care operations. I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I authorize the dental provider to consult with my medical provider(s) as may be appropriate to my health and the provision of dental care. If I have dental insurance, I authorize my insurance carrier to be billed for any services provided. I understand that this treatment may affect my future rights and benefits under my dental insurance. If I do not have dental insurance, I will pay the Dental Provider for all dental services that are charged to me.

I understand this office requires a MINIMIMUM notice of 24 hours for an appointment cancelation. Multiple last minute cancelations or not showing for an appointment will result in dismissal from our practice and/or failed appointment fees.

X______________________________________ **Date**: ___/___/___ **Relationship to Patient**: _____________________
Patient/Legal Representative Signature



Financial Policy

827 Robbins Ave.
Niles, OH 44446
Phone: 330.652.2676
Fax: 330.652.0994

Thank you for choosing Niles Family Dentistry for your dental needs. Dental treatment is an excellent investment in your medical and psychological well-being. We are committed to providing you with the best possible care to achieve total oral health. Unless other financial arrangements are made, payment in full is due at the time services are provided. For your convenience, we accept the following methods of payment: Cash, Check, CareCredit, MasterCard, Visa and Discover. If you have dental insurance, we are eager to help you receive your maximum allowable benefits. However, our office does not guarantee payment or coverage by your insurance company. We will always do our best to anticipate any out of pocket expense prior to your appointment, but this is only an estimate based on info given to us by your insurance company.

1. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. As dental care providers our financial relationship is with you, the patient, not your insurance company.
2. We cannot render services on the assumption that charges will be paid for by an insurance company. While filing the insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We recommend that you contact your insurance carrier to become familiar with your insurance coverage.
4. Balances over 90 days will be subject to turning over to a collection agency. Should referral to an attorney or collection agency become necessary, an additional collection charge of the outstanding balance will be added to the account to defray the cost of collection plus attorney fees and court costs. I understand that my credit rating may be adversely affected should this account be entered for collections.
5. All returned checks will have an additional reprocessing fee of $25 charged to the account.

I have read the policies described in this form. I understand and agree to abide by the terms outlined in this financial policy agreement. I understand and accept my financial responsibilities.

I, ______________________________ (Responsible party name) am acknowledging that I am financially responsible for ____________________________ (Patient name).

Signature of responsible party:____________________________________ Date:____________
Relationship to patient:____