WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age:_____ SS #: _____

Home Address: _____
APT/CONDO #:

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (_____)_____ Pager / Cell #: _____

Wk #: (_____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (_____) _____ Ext: ____ SS #: _____

Birthdate: ___/___/___ Driver's License #: _____

Person Responsible for Account: _____

Wk #: (_____)_____ Ext: ___ Hm #: (_____)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 Insurance Coverage

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: (_____) _____ Hm #: (_____)_____

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:

Phone #: (_____) _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/ over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-fen? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol / Drug Abuse	Y	N	Herpes / Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+ / AIDS
Y	N	Artificial Bones / Joints / Valves	Y	N	Hospitalized for Any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer /Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic / Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Metals
Y	N	Codeine	Y	N	Jewelry	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Tetracycline

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature **Date**

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____

Signature **Date**

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. **Initials:** _____ **Date:** _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____

Sansone Family Dental Practice, L.L.P.
Frank V. Sansone, D.D.S.
David F. Sansone, D.D.S.
Thomas R. Sansone, D.D.S.
4343 Dewey Avenue
Rochester, NY 14616
585-663-1390

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. The following is a statement of our Financial Policy which we ask you to read carefully and sign prior to treatment.

Regarding Insurance:

Your insurance policy is a contract between you and your insurance company.

It is our policy to charge our patients and their insurers in a fair and consistent manner. Our fees are set at usual and customary rates for this area.

All insurance information including changes and updates need to be provided to us at time of service.

Copayments are due at time of service.

When assignment of benefits is accepted, we will **estimate** your copayment, which will be due on the date services are rendered. Please note, some, and perhaps all, of the services provided may be non-covered services under your insurance plan. In this instance, a statement will be mailed to you and payment is expected upon receipt.

In the event there is no insurance, or if we do not accept assignment of benefits, we require payment in full at time of service.

We accept cash, checks, Mastercard, Visa, American Express, and Discover, as well as Care Credit. Should you make a payment by check and if it is returned, a fee of $40.00 will be charged to your account.

Broken Appointments and Cancellations

There will be a fee based on visit type for broken appointments or cancellations not made 24 hours in advance of appointment.

In the event that Sansone Family Dental Practice, L.L.P. pursues civil remedies against me for the collection of my financial obligations for services rendered, I hereby agree to be responsible for reasonable collection and/or attorney fees and disbursements incurred by Sansone Family Dental Practice, L.L.P.

I have read this Financial Policy and understand and agree to be personally and fully responsible for payment.

PATIENT SIGNATURE_____
(Legal Guardian if under 18 years of age)

DATE _____

SANSONE FAMILY DENTAL PRACTICE, L.L.P.
Frank V. Sansone, D.D.S.
David F. Sansone, D.D.S.
Thomas R. Sansone, D.D.S.
4343 Dewey Avenue
Rochester, NY 14616
(716) 663-1390

Family Dentistry for the Quality Conscious

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

ITEM 070-5962/25950 © MAY 2002

SANSONE FAMILY DENTAL PRACTICE, L.L.P.
David F. Sansone, D.D.S.
Thomas R. Sansone, D.D.S.
4343 Dewey Avenue
Rochester, NY 14616
585-663-1390
Family Dentistry for the Quality Conscious

CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME_____

We will use the following methods to contact you in order to conduct business relating to your dental/medical treatment, including, but not limited to, appointments, reminders, medical results, billing and/or insurance questions:

Home Phone, Work Phone, Cell Phone, Text Message, With another person, Via mail, Via email/electronically.

Please indicate below if there are any methods you **do not** want us to use.

_____

Is there a family member, friend, or person responsible for your care that you would like us to be able to communicate with regarding your treatment and/or information from this office? If so, please list below:

Name	Relationship
_____	_____
_____	_____
_____	_____

Patient Signature_____Date_____
or
Parent/Guardian Signature_____Date_____