New Patient Information

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us- we will be happy to help.

Whom may we thank for referring you? ____

Name: ______________________ prefer to be called __________ [ ] **Male** [ ] **Female**
[ ] Single [ ] Married [ ] Partnered [ ] Child [ ] Widowed [ ] Divorced [ ] Separated
Birthdate:_____/_____/_____ **S.S. #** ______________________________
Home Address: ______________________ **City**_____________ **State**_____ **Zip** _______
Home Phone: (____)________ **Work:** (____)________ ext._____ **Cell:** (_____)______________
E-mail Address: ____
Employer: ______________________________ **Occupation:** ______________________

Person Responsible For Account

[ ] Same as above
Name: ______________________________ Birth date: ____/___/___ Relation: __________
Home Address: ______________________ City_____________ State_______ Zip __________
Home Phone: (____)________ Work: (____)__________ ext._____ Cell: (_____)______________
E-mail Address: ____
Employer: ______________________ Occupation: ______________________________

Preferred Pharmacy: ____
Phone Number: ____
Address: ____

Emergency Contact

Name: ____
Phone Number: ____
Relation: ____

Dental Insurance Information

Primary Insurance:
Insurance Co. Name:______________________ Phone: (____) _________ Group/Policy # ________
Insured's Name:________________________ Insured Birth date: ___/___/___ Relation____________
Insured SS/ Member ID#:__________________ Insured's Employer/ Union Number: ______________

Secondary Insurance:
Insurance Co. Name:______________________ Phone: (____) _______ Group/Policy # ___________
Insured's Name:________________________ Insured Birth date: ___/___/___ Relation____________
Insured SS/Member ID #:_____________ Insured's Employer/ Union Number: __________________

Please see page 2

Medical History Information

Name of Physician: ___________________________________ **Phone:** (___)________________________________

Do you have or have ever had any of the following? Please check those that apply:

AIDS/ HIV*	Diabetes	Hemophilia	Rheumatic Fever
Allergies/Hay Fever	Drug Addiction	Hepatitis	Rheumatism
Anemia	Epilepsy or Seizures	High Blood Pressure	Sickle Cell Disease
Angina/ Chest Pain	Fainting or Dizziness	High Cholesterol	Sinus Problems
Arthritis	Fever Blisters/ Cold Sores	Kidney Disease	Sleep Apnea
Artificial Joints*	Glaucoma	Liver Disease	Stomach/ Intestinal Disease
Artificial Heart Valves*	Heart Attack/ Failure	Mental Disorders	Stroke
Asthma	Heart Disorder (Congenital)*	Mitral Valve Prolapse	Tumors
Blood Disorder	Heart Infection*	Osteoporosis	Thyroid Problems
Cancer (type)_________	Heart Murmur	Radiation Treatment	Tuberculosis
Chemotherapy	Heart Pacemaker	Respiratory Problems	Ulcers

* This condition may require antibiotic premedication for certain dental procedure

Yes No

[ ] [ ] Do you have any health problems that were not listed above or need further clarifications?
If yes explain:____

[ ] [ ] Are you now under the care of a physician?
If yes explain:____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, explain____

[ ] [ ] Are you taking any **medications** or herbal medications?
If yes, please list them here:

____
____
____

[ ] [ ] Are you **allergic** to any medications or substances?
If yes, please check box below:
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Other__________________________

[ ] [ ] Have you used tobacco? If yes, explain: ____

Women (Please check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

Please see page 3

Dental Health Questionnaire

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan. We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern.

Once all your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there. We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together.
Please help us better understand your dental health need and goals by answering the following questions.

1. I have a [ ] **low** [ ] **moderate** [ ] **high** fear of going to the dentist

2. My mouth and teeth are [ ] **ver**y [ ] **moderately** [ ] **not** comfortable

3. I am [ ] **very satisfied** [ ] **satisfied** [ ] **dissatisfied** with the appearance of my teeth

4. I think my present state of dental health is [ ] **excellent** [ ] **good** [ ] **fair** [ ] **poor**

5. I would say that my **main concerns** with my dental health are:

____

____

6. **My last visit to the dentist was (date)** ____

7. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years?
[ ] **Yes** [ ] **No**

8. If Applicable, please provide your previous dentist's name and information:

____

____

____

Please see page 4

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you .Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **2 working days advanced notification** so that we may use our time to accommodate other patients. **Broken and missed appointments create scheduling problems for other patients and our practice. Due to this we do have broken appointment fee of $85.** We value your time, please value ours.

FINANCIAL POLICY

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. For your convenience we accept Cash, Care Credit, American Express, Visa, MasterCard, Discover, and personal check at our discretion.
As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. **If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and will be reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company.** All current documentation will be provided by mail in order to assist your inquiries. The insured has a better ability to deal with the insurance company and the employer responsible for the policy.
Finance Charge and Fees: Returned checks are subject to a $45 accounting fee.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Cucchiara. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Cucchiara to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Cucchiara.

If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment.
I understand and agree to the **Appointment Policy**.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.

X ____ Date ________________________
Signature of patient, parent or guardian

NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that I may ask any questions I might have regarding this notice.

X ____ Date ______________________

Signature of patient, parent or guardian