Patient Information

Patient Name: _____ Male / Female ___ Married ___ Single ___ Child

Birth Date: _____/_____/_____ Social Security #: _____-_____-_____

Address: _____ Whom may we thank for referring you to our practice?

_____ _____

_____ _____

Phone (Home): _____ (Work): _____ (Cell):_____

E-Mail:_____ Driver's License # _____

Emergency Contact (Name and Phone #): _____ Relation: _____

Responsible Party Information

The following is for the person responsible for payment: _____ Self _____ Spouse _____ Parent or Guardian

Name: _____ Phone: _____

Birth Date: _____/_____/_____ Social Security #: _____-_____-_____

Insurance Information

PRIMARY

Name of Policy Holder_____ Is this person a patient at our office? **Y** or **N**

Insurance Plan Name _____ Insurance Telephone: _____

ID #: _____ Group #: _____ Policy Holder's Birth Date: _____/_____/_____

Policy Holder's Employer and Phone #: _____ Position: _____

SECONDARY

Name of Policy Holder_____ Is this person a patient at our office? **Y** or **N**

Insurance Plan Name _____ Insurance Telephone: _____

ID #: _____ Group #: _____ Policy Holder's Birth Date: _____/_____/_____

Policy Holder's Employer and Phone #: _____ Position: _____

I understand that payment is required for all services rendered on the date of services unless other arrangements are made in advance and that my insurance will be filed as a courtesy service. I hereby authorize the Oak Family Dentistry, Dr. Peter Sciarrino, to release all information necessary to secure the payment of benefits directly to the office, unless other arrangements have been made. I understand that I am responsible for all charges whether or not they are covered by insurance benefits.

Signature: _____ Date: _____

Health Information

Have you ever had any of the following? Please check all that apply:

___AIDS/HIV Positive ___Bruise Easily ___Fainting/Dizziness ___High Cholesterol ___Radiation Treatment

___Alzheimer's ___Cancer ___Genital Herpes ___Hypoglycemia ___Renal Dialysis

___Anaphylaxis ___Chemotherapy ___Glaucoma ___Kidney Problems ___Rheumatic Fever

___Anemia ___Cold Sores/Fever Blisters ___Hay Fever ___Leukemia ___Rheumatism

___Angina ___Congenital Heart Disorder ___Heart Attack/Failure ___Liver Disease ___Sickle Cell Disease

___Arthritis/Gout ___Convulsions ___Heart Murmur ___Lung Disease ___Intestinal Disease

___Artificial Heart Valve ___Cortisone Medicine ___Heart Pacemaker ___Mitral Valve Prolapse ___Stroke

___Artificial Joint ___Diabetes ___Hemophilia ___Osteoporosis ___Thyroid Disease

___Asthma ___Drug Addiction ___Hepatitis A, B, or C ___Pain in Jaw Joints ___Tuberculosis

___Blood Disease ___Emphysema ___Herpes ___Parathyroid Disease ___Ulcers

___Blood Transfusion ___Epilepsy/Seizures ___High Blood Pressure ___Psychiatric Care ___Venereal Disease

Are you under a physician's care? **Y** or **N** If yes, please explain: _____

Have you ever been hospitalized or had a major operation? **Y** or **N** If yes, please explain: _____

Have you had a serious head/neck injury? **Y** or **N** If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? **Y** or **N** If yes, please explain: _____

Do you use tobacco products? **Y** or **N** Do you use controlled substances? **Y** or **N**

Women (Please check all that apply): ____Pregnant ____Trying to get pregnant ____Nursing ___Taking Oral Contraceptives

Are you allergic to the following? (Please check ALL that apply.)

___Aspirin ___Penicillin ___Local Anesthetics ___Acrylic ___Metal ___Latex ___Sulfa Drugs ___Other: _____

Have you ever had a serious illness not listed above? **Y** or **N** If yes, please explain: _____

Medications:

_____

Dental History

Reason for today's visit: ____Exam ____Emergency ____Consultation Are you in Pain? **Y** or **N** How long? _____

Please indicate any of the following problems or issues:

____Discomfort, Clicking or Popping Jaw ____Lost/Broken Fillings ____Stained Teeth ____Broken/Chipped Tooth ____Anxiety

____Blisters/Sores Around the Mouth ____Teeth Grinding ____Locking Jaw ____Sensitive Tooth, Teeth, or Gums

____Red/Swollen Bleeding Gums ____Bad Taste in Mouth ____Bad Breath ____Active Decay/Cavities

Previous Dentist: _____ Phone #: _____ Last Dental Exam: _____/_____/_____

Rate Your Smile (10 Excellent): _____ Would you like whiter teeth? **Y** or **N** Have you had orthodontic treatment? **Y** or **N**

Things you would change about your smile, teeth, or mouth? _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform Dr. Sciarrino and the staff at the next appointment without fail.

Signature: _____ **Date:** _____

Appointments

Here at Oak Family Dentistry 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. **Unless given the required notice, a cancelled or broken appointment charge will be $75.**

FINANCIAL POLICY

Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment. Should a patient have dental insurance with an assignment to Dr. Peter Sciarrino, Oak Family Dentistry; the estimated patient portion will be the amount due. Our practice is committed to providing the best dental treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **In order to accommodate our patients, Oak Family Dentistry is an In-Network Provider for most major dental insurances**. Please be sure to check if we are a Preferred-Provider for your insurance.

Payment Options

1) For your convenience we accept Cash, Check, Visa, MasterCard and/or Care Credit
2) We also offer short and long-term financing options. (Interest-free options may apply. See the front desk to see if you are applicable.)

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. We pride ourselves here at Oak Family Dentistry on making sure our patients understand their dental benefits and how they relate to your specific needs before any dental treatment is started. However, all estimates given are not a guarantee of payment by the insurance and any costs not paid in full by the insurance company will be the patient or Guarantor's responsibility.

Finance Charge and Fees

-Overdue balances in excess of 60 days are subject to a finance charge of 1.5% per month (18% annual).
-Returned checks are subject to a $35 checking fee.

Authorization and Consent

General Consent to Treatment

I agree and consent to a dental examination by Dr. Peter Sciarrino. 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 Information

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

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Peter Sciarrino, Oak Family Dentistry.

Photography Release

I authorize Dr. Peter Sciarrino to take photographs of me to help me better understand my current dental condition and possible treatment options.

I have read and understand the Appointment Policy, Financial Policy, and General Consent of Treatment and will comply with Oak Family Dentistry's office policies. I authorize the Release of Information and necessary photographs taken of me.

SIGNATURE: _____ **DATE:** _____

OAK FAMILY DENTISTRY

Acknowledgement of Receipt

Notices of Privacy and Practices

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

SIGNATURE: _____ **DATE:** _____