RONCONE FAMILY DENTAL 3171 Chili Avenue, Suite 300 Rochester, NY 14624 (585)889-2870

DATE:_____/_____/_____

WELCOME!

Thank you for choosing RONCONE FAMILY DENTAL. **Please fill out this form as completely as you can. If you have any questions, we will be happy to help. (Please print)**

PATIENT INFORMATION

Name_____ ( )Dr. ( )Mr. ( )Mrs. ( )Ms. ( )Rev. ( )Other
First MI Last
Address_____ City_____ State____
Zip_____
Home Phone # (____)_____ Cell Phone # (____)_____
( )Male ( )Female Are you: ( )Minor ( )Married ( )Single ( )Divorced ( )Widowed ( )Separated
DOB_____/_____/_____ SSN # _____
Email_____
Occupation_____ Employer_____ Wk # (____)_____ Ext____
Name_____ Cell Phone # (____)_____
First MI Last (if different)
Spouse's Occupation_____ Wk # (____)_____ Ext_____
Is patient a full time student? ( )No ( )Yes If Yes, Name of
School_____

RESPONSIBLE PARTY (If different than patient)
Name_____
First MI Last
Address_____
City_____ State_____ Zip_____
Home # (____)_____
Wk # (____)_____ Ext_____
at:
DOB_____/_____/_____
SSN # _____
Relationship_____

Whom may we thank for referring you?
_____

YOUR PREFERENCES (How would you like to be contacted?)
Do you prefer appointment reminder by:
( )Email ( )Phone ( )Text
Do you prefer to receive calls from our office

( )Home ( )Cell ( )Work
How do you wish to be addressed by our staff?
_____

INSURANCE INFORMATION

Dental Insurance:

Insured Name/Subscriber_____ Relationship to patient_____
Address_____ City_____ State____
Zip_____
DOB_____/_____/_____ SSN # _____ Employer_____
Insurance Company_____ Member ID_____
DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ( )Yes ( )No If yes, please complete the following:
Insured Name/Subscriber_____ Relationship to patient_____

Address_____ City_____ State____
Zip_____
DOB_____/_____/_____ SSN # _____ Employer_____
Insurance Company_____ Member ID_____ Group#_____
Effective Date_____/_____/_____
Please present copy of insurance card at your appointment

MEDICAL HISTORY

Lung Disease	Y	N
Lupus	Y	N
Mental Disorder	Y	N
Mitral Heart Valve	Y	N
Organ Transplant	Y	N
Osteoporosis	Y	N
Psychiatric Care	Y	N
Radiation Therapy	Y	N
Respiratory Problems	Y	N
Rheumatic Fever	Y	N
Sinus Trouble	Y	N
Stroke	Y	N
Swelling of Limbs	Y	N
Thyroid Disease	Y	N
Tumors or Growths	Y	N
Ulcers	Y	N
Venereal Disease	Y	N

ORAL		
Bleeding Gums	Y	N
Dry Mouth	Y	N
Jaw Problems (TMJ)	Y	N
Clicking?	Y	N
Pain?	Y	N
Difficulty Swallowing?	Y	N
Difficulty Chewing?	Y	N
Difficulty Opening/Closing?	Y	N
Periodontal Disease	Y	N

Periodontal Treatment	Y	N
Teeth Grinding/Clenching	Y	N
Bite Plate/Mouth Guard	Y	N
Serious Injury to mouth or head	Y	N
Tooth Pain	Y	N

SLEEP		
Daytime Sleepiness	Y	N
Morning Headaches	Y	N
Sleep Apnea	Y	N
Do you use a CPAP?	Y	N
Do you Snore?	Y	N

Do you have of have you had any of the following? (Circle Y if you have or have had)

Acid Reflux	Y	N
ADHD	Y	N
AIDS/HIV Positive	Y	N
Alzheimer's Disease	Y	N
Anaphylaxis	Y	N
Anemia	Y	N
Anxiety	Y	N
Arthritis/Gout	Y	N
Artificial Joint Replacement	Y	N
Artificial Heart Valve	Y	N
Bladder Problems	Y	N
Blood Disease	Y	N
Breathing Problems	Y	N
Cancer Affected Area_____	Y	N
Chemotherapy	Y	N
Chest Pains	Y	N
Cold Sores/Fever Blisters	Y	N
Depression	Y	N
Diabetes	Y	N
Drug Addiction	Y	N

Eating Disorder	Y	N
Emphysema	Y	N
Epilepsy or Seizures	Y	N
Excessive Bleeding	Y	N
Fainting Spells/Dizziness	Y	N
Fibromyalgia	Y	N
Glaucoma	Y	N
Heart Attack/Failure	Y	N
Heart Murmur	Y	N
Heart Surgery	Y	N
Heart Pacemaker	Y	N
Heart Disease	Y	N
Hepatitis Type _____	Y	N
Herpes	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Leukemia	Y	N
Liver Disease	Y	N

LIST OF KNOWN ALLERGIES
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.

Do you take or need an Antibiotic before dental Procedures? **If Y, List below**	Y	N

SOCIAL HISTORY		
Do you Smoke? Packs per day? _____	Y	N
Do you use smokeless tobacco?	Y	N
Do you consume alcoholic beverages? ____ drinks per day/week/month	Y	N
Do you use recreational drugs?	Y	N

Have you taken any Bisphosphonate drugs for Osteoporosis such as Fosamax, Actonel, Boniva or other?	Y	N
Have you taken any blood thinning medications such as Plavix, Coumadin, Warfin or other?	Y	N

MEDICAL HISTORY (Continued)

Medications **Reason** **Prescribing Physician**

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

☐ N/A

List any surgeries or hospitalizations you have had:

Date (year) **Surgery** **Surgeon** **Reason**

1._____
2._____
3._____
4._____
5._____
6._____

☐ N/A

List and detail any medical conditions or history not listed above:

_____
_____

Women, are you?

( )Pregnant ( )Nursing ( )Taking oral contraceptives ( )IUD ( )Trying to get pregnant

_____
_____

Primary Physician's Name_____ Physician's Phone #
(____)_____

Preferred Pharmacy Name_____ Pharmacy Phone #
(____)_____

Are you under the care of other physicians? If Yes, please list:

Physician Name	Physician Phone Number	Reason
	( )	
	( )	
	( )	

When was your last dental visit? _____

CONSENT

GENERAL CONSENT TO DIAGNOSE & TREAT:

The undersigned hereby authorizes Roncone Family Dental to take radiographs, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Roncone Family Dental to try to perform any, and all forms of treatment, medication, and therapy that may be necessary and further consent that Roncone Family Dental choose and employ such assistance as deemed necessary. I understand that the use of local anesthetic agents (Novocain) embodies certain risk and consent to their use as deemed appropriate by Roncone Family Dental. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any changes in medical health or status.

FINANCIAL CONSENT:

I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental, if any. I further consent to agree to pay a 1.5% finance charge that will be applied to any balance over 60 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Roncone Family Dental and staff to verify insurance coverage, if any, to submit claims and provide any insurance

company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

CONSENT (Adult)

_____

Name of Patient

_____ _____

Signature of Patient Date

CONSENT (for a minor child)

_____ _____

Name of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date

NOTICE OF PRIVACY PRACTICES

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health (PII) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below, you are acknowledging receiving notice of our practices, policies, and your rights regarding PHI. I allow the release of pertinent medical records to my insurance company, if applicable and my other medical providers.

_____ _____

Signature of Patient Date

CANCELLATION POLICY

This policy is frequently reviewed by our staff to ensure proper patient care, improve office efficiency, and make patients visits as smooth as possible. Roncone Family Dental is commonly scheduled weeks to months in advance for treatment and cleaning appointments. Failure to keep an appointment could push your treatment back a significant amount of time. Also, failed appointments or short notice cancellations do not allow enough time to fill the schedule time, preventing other patients' needs unserved.

Patients must inform our office staff of any appointment changes prior to 24 hours of the appointment time to prevent documentation of a short notice cancellation alert on the account. Any appointments that are cancelled within 24 hours of the appointment will be documented and patients may be required to provide a credit card number to reserve future appointments.

Our office may refuse to schedule multiple family members for treatment on the same date of service if a history develops of short notice cancellations or failed appointments.

Same day cancellations or no show will be documented in the patient account as a failed appointment and patients will be required to prepay for any future appointments and may be charged $45.00 per appointment cancellation fee.

_____

Name of Patient

_____ _____

Signature of Patient Date