

Patient Information			
Name:	Last	First	MI
How do you wish to be addressed ?			
Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male	Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Minor
If Minor, Parent's Name			
Date of Birth:	(MM/DD/YYYY)		Social Security Number:
Other Family Members in this Practice:			
Drivers License Number	State		
Residence Street	City	State	Zip
Home Phone #	Work #	Cell #	
Email Address	Fax #		
How do you wish to be contacted ? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email			

Patient/Parent Employer Information		Dental Insurance	
Name		<input type="checkbox"/> I am the policy holder for this plan (skip shaded boxes below)	
Street Address		Employee Name: Last First MI	
City	State	Employee Social Security #	
Whom may we thank for this referral?		Employee Date of Birth: Month Day Year	
Internet Search: <input type="checkbox"/> Google <input type="checkbox"/> Bing <input type="checkbox"/> Yahoo		Patient Relationship to Employee <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Other	
<input type="checkbox"/> Other: _____		Employer Name	
Direct Referral: <input type="checkbox"/> Spouse <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Doctor		Insurance Company Name	
Name: _____		Insurance Company Address	
Did you view our website prior to your visit ? YES/NO		City State Zip	
Comments about our website are greatly appreciated so that we can consider making improvements if necessary. Please feel free to comment here: _____		Insurance Company Phone	
		Group / Program / Policy #	
		If you have a secondary insurance policy, please indicate here <input type="checkbox"/>	

Patient Primary Care Physician	
Are you currently under a physician's care? YES/NO	When was your last complete physical exam? _____
Physician's Name: _____	Reason: _____
Phone Number: _____	

Medical History
Are you taking any medications or substances (including herbal remedies, vitamins, etc.)?.....YES/NO
If so, please list: _____

Do you have allergies to any of the following?			
Antibiotics (i.e., Penicillin) Please Indicate: _____	YES/NO	Medications Please Indicate: _____	YES/NO
Anesthetics Please Indicate: _____	YES/NO	Metals Please Indicate: _____	YES/NO
Latex	YES/NO	Seasonal Allergies	YES/NO

Medical History, continued.....			
Do you have a history of the following? (please check all that apply)			
CARDIOVASCULAR	NEUROLOGY	ENDOCRINE	MISCELLANEOUS
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Fainting/Dizzy Spells	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Cancer Chemotherapy
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Excessive Thirst/Hunger	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Heart Murmur			<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure	JOINT DISEASE	RESPIRATORY	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Asthma	<input type="checkbox"/> Recreational Drug Use
	<input type="checkbox"/> Artificial joints/prostheses	<input type="checkbox"/> COPD	Do you drink alcohol? YES/NO
BLOOD DISORDERS		<input type="checkbox"/> Lung Disease	How many drinks/week? _____
<input type="checkbox"/> Anemia	GENITO-URINARY	Do you smoke? YES/NO	<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stomach Problems	If so, how many packs/day? _____	
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Liver Disease	For how many years? _____	
	<input type="checkbox"/> Kidney Disease	Do you chew tobacco? YES/NO	
PLEASE ANSWER THE FOLLOWING			
Do you have any disease not listed above?			YES/NO
Please indicate: _____			
Is there anything else we should know about your health that is not covered on this form?			YES/NO
If so, explain: _____			
Would you like to speak to the Doctor privately about any problem?			YES/NO

Dental History	
Purpose of initial visit: _____	
Are you aware of a problem?	YES/NO
Do you have a recent copy of your xrays?.....	YES/NO
Have you made regular dental visits in the past?.....	YES/NO
When was the last time you had a dental cleaning? _____	
Have you lost teeth or have any teeth been removed?.....	YES/NO
Why? _____	Have you had any lost teeth replaced?.....
	YES/NO
Do you experience sensitivity in any of your teeth?.....	YES/NO
To What? <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Sweets <input type="checkbox"/> Pressure <input type="checkbox"/> Chewing	Do you currently have any discomfort in your mouth?.....
	YES/NO
Do you clench or grind your teeth?.....	YES/NO
Where? <input type="checkbox"/> Upper Right <input type="checkbox"/> Upper Left <input type="checkbox"/> Lower Right <input type="checkbox"/> Lower Left	Does your jaw click or pop?.....
	YES/NO
Do you experience pain or soreness in or around your face or around your ear?.....	YES/NO
Do you have frequent headaches, neck aches or shoulder aches?.....	YES/NO
Does food get caught in your teeth?.....	YES/NO
Do your gums bleed or hurt?.....	YES/NO
How often do you brush your teeth? _____	Do you floss regularly?.....
	YES/NO
Are you unhappy with the appearance of your teeth?.....	YES/NO
Are you unhappy with your breath at times?.....	YES/NO

I affirm the accuracy of this medical and dental history. Signature _____	Date _____
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Financial Agreement & Privacy Policy

Financial Policy & Patient Responsibilities

Our office is out-of-network with all major insurance companies. For basic and major services (i.e., fillings, crowns, dentures, etc.), payment is required once treatment has been rendered. In rare circumstances, we may accept payment from your insurance company directly for diagnostic treatment and routine dental cleanings. As a courtesy, we will submit all insurance claims to your insurance company for your reimbursement.

Insurance Payments

Co-payments and/or insufficient payment not otherwise made by your insurance company are ultimately your responsibility in addition to any procedures not covered by your dental insurance. Balances exceeding 30 days for treatment completed are subject to a 22% finance charge (per annum).

Please understand that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Regardless of insurance status, you are ultimately responsible for the balance of your account.

Last-minute Cancellations, Missed Appointments & Lateness

A fee of \$100 per hour appointed will be incurred for the first missed/canceled appointment. For 2 or more missed/canceled appointments, a fee of \$250 per hour appointed will be assessed and it will be necessary for payment to be made in full for the scheduled procedure(s) prior to rescheduling your visit. If you are running more than 20 minutes late, we reserve the right to reschedule your visit; please understand that a broken appointment fee may be applied to your account. Since we reserve specific time slots for each and every patient, we kindly request notice of at least 48 hours in advance should you need to reschedule your appointment.

Acknowledgement of Privacy Policy

With your permission, Dr. Gulizio and Dr. Cordoves may use and disclose protected health information (PHI) about you to carry out treatment, payment and healthcare operations (TPO). You have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Gulizio and Dr. Cordoves reserve the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer. With your permission, the office of Dr. Gulizio and Dr. Cordoves may call your home or other designated locations and leave a message on voice mail, email, text message, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With your permission, the office of Dr. Gulizio and Dr. Cordoves may mail to your home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. Additionally, the office of Dr. Gulizio and Dr. Cordoves may use photographs, study models and other treatment records as documentation for lectures and learning objectives in an educational setting. At no point in time will your identity--visually or by name--be disclosed. You have the right to request that Dr. Gulizio and Dr. Cordoves restrict how they use or disclose your PHI to carry out TPO. However, the practice is not required to agree to your requested restrictions, but if it does, it is bound by this agreement. By signing this agreement, you are allowing the office of Dr. Gulizio and Dr. Cordoves to use and disclose your PHI for TPO. You may revoke your consent in writing except to the extent that the practice has already made disclosure in reliance upon your prior consent.

Informed Consent (please initial)

___I consent to the diagnostic procedures and treatment necessary for proper dental care.

___I consent to the disclosure of my records (or my child's records) to the office staff, insurance companies, partner companies and other persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure of records shall be effective until I revoke it in writing.

___I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services and that I am financially responsible for payment in full of all accounts.

By initializing and signing this agreement, I revoke all previous agreements to the contrary and agree to be fully responsible for payment of dental services provided. I understand that a service charge of 22% per annum will be applied on any unpaid balance for completed procedures on all accounts exceeding 30 days, unless written financial arrangements are satisfied. I understand that the fee estimate listed for my dental care can only be extended for a period of 3 months from the date of my initial examination.

My signature below indicates that I am a native speaker of the English language and have had the opportunity to ask questions regarding this agreement.

_____ Date _____