

**PATIENT INFORMATION**

NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
 CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ APT. # \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 SOCIAL SECURITY NUMBER: \_\_\_\_\_; ATTENDING SCHOOL YES NO; GRADE \_\_\_\_\_; NAME \_\_\_\_\_

EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	MONTH	DAY	YEAR	AGE	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	WEIGHT	HEIGHT	EYES (COLOR)
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EMPLOYER'S NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
 EMPLOYER'S ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ BUS. PH #: \_\_\_\_\_

**PARTY RESPONSIBLE FOR THIS ACCOUNT**

NAME: \_\_\_\_\_ SPOUSE NAME: \_\_\_\_\_ HOME PH#: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_

EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	MONTH	DAY	YEAR	AGE	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	WEIGHT	HEIGHT	EYES (COLOR)
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RELATIONSHIP TO PATIENT: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
 EMPLOYER'S NAME: \_\_\_\_\_ BUSINESS PH# \_\_\_\_\_ EXT# \_\_\_\_\_  
 EMPLOYER'S ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**PAYMENTS TO BE MADE BY**

CASH <input type="checkbox"/> YES	MASTER CARD ACCOUNT # _____ EXP. DATE _____	VISA ACCOUNT# _____ EXP. DATE _____	CHECK BANK _____ A/C# _____
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**RESPONSIBLE PARTY INSURANCE**

PATIENT OR GUARDIAN DENTAL INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO	INSURANCE NAME: _____	PH# _____	INSURED PARTY S/S# _____
	EMPLOYER: _____	GROUP OR POLICY# _____	
	SEND CLAIMS TO: _____	COVERAGE: <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY	
	SPOUSE NAME: _____	DOB _____	SOCIAL SECURITY# _____
SPOUSE DENTAL INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO	SPOUSE INSURANCE NAME: _____	PHONE # _____	
	EMPLOYER: _____	GROUP OR POLICY# _____	
	SEND CLAIMS TO: _____	COVERAGE: <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY	

**OTHER**

PREVIOUS DENTIST'S NAME & ADDRESS \_\_\_\_\_  
 PHYSICIAN'S NAME & ADDRESS \_\_\_\_\_  
 IN CASE OF EMERGENCY NOTIFY (NOT LIVING WITH PATIENT) NAME: \_\_\_\_\_  
 RELATIONSHIP TO PATIENT: \_\_\_\_\_ PHONE (NO(S)): \_\_\_\_\_

WHOM SHALL WE THANK FOR REFERRING YOU? \_\_\_\_\_

DRIVER'S LICENSE NO. (Individual responsible for account only)  
 \_\_\_\_\_ STATE \_\_\_\_\_

I hereby acknowledge above information is true and correct:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 Party Responsible for Account

**MEDICAL HISTORY** (PLEASE CIRCLE OR NO) **BP** / **ulse**

- 1. Has there been a recent change in your health? ..... No Yes  
If yes, please explain: \_\_\_\_\_
- 2. When was your last examination? \_\_\_\_\_
- 3. Are you under the care of a physician? ..... No Yes  
If yes, condition: \_\_\_\_\_
- 4. Have you been hospitalized or had a serious illness within the last 5 years? ..... No Yes  
If yes, what was the problem? \_\_\_\_\_
- 5. Do you have or have you had any of the following? ..... No Yes  
(Please check appropriate conditions)
 

<input type="checkbox"/> Rheumatic Fever or Heart Problems	<input type="checkbox"/> HIV Infection or Aids	<input type="checkbox"/> Asthma or Hay Fever
<input type="checkbox"/> Abnormal Bleeding/Blood Disorders	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Fainting Spells or Seizures
<input type="checkbox"/> Arthritis or Rheumatism	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Hepatitis, Jaundice or Liver Disease	<input type="checkbox"/> Orthopedic Appliances	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> GI Problems (Ulcers)	<input type="checkbox"/> Surgical Procedures	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Nervous Problems	
- 6. Do you have any difficulty breathing through your nose? ..... No Yes
- 7. Are you currently taking any medication, either prescribed or over the counter? ..... No Yes  
If yes, list \_\_\_\_\_
- 8. Are you allergic to any drugs or medications such as Penicillin, Codeine, Aspirin or local anesthetics? ..... No Yes  
If yes, what \_\_\_\_\_
- 9. Do you have any disease condition or other problems listed above that you think I should know about? ..... No Yes  
If yes, describe \_\_\_\_\_
- 10. Are you aware of any lumps in your mouth? ..... No Yes
- 11. Do you use tobacco products? ..... No Yes

**WOMEN ONLY**

- 1. Are you pregnant? If so, how many months? \_\_\_\_\_ No Yes
- 2. Are you taking birth control pills? ..... No Yes

**DENTAL HISTORY**

- 1. Are you aware of any dental problems at this time? ..... No Yes
- 2. When was your last dental visit? \_\_\_\_\_  
What was performed? \_\_\_\_\_
- 3. Are you seen in a dental office on a regular basis? ..... Yes No
- 4. Have you had a set of full mouth X-rays in the last 3 years? ..... No Yes  
If no, when was the last set? \_\_\_\_\_
- 5. Have you had a dental cleaning within the last year? ..... Yes No  
If not, when was your last cleaning? \_\_\_\_\_
- 6. Have you had any of the following treatment? Orthodontics, Endodontics (Root Canal), Periodontics (Gum Therapy). If yes, please specify: \_\_\_\_\_ No Yes
- 7. Do you experience pain or clicking in your jaw, ear, or facial muscles upon opening your mouth? ..... No Yes
- 8. Have you ever had instructions in oral hygiene technique? ..... Yes No
- 9. How often do you brush your teeth? \_\_\_\_\_
- 10. Do your gums bleed? ..... No Yes
- 11. Are you aware of grinding or clenching your teeth? ..... No Yes
- 12. Do you suffer anxiety or gagging during dental procedures? ..... No Yes
- 13. How are your teeth important to you? \_\_\_\_\_
- 14. Do you want to avoid dentures? Why: \_\_\_\_\_ Yes No
- 15. Are you unhappy with the appearance of your teeth? ..... No Yes  
Why: \_\_\_\_\_
- 16. What changes would you make? \_\_\_\_\_
- 17. Interests and hobbies? \_\_\_\_\_

Patient's (or Guardian's) Signature \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date: \_\_\_\_\_

Dr. Joseph G. Chiafair, D.D.S & Associates

Dear Patient,

We appreciate you allowing us to provide you with dental care and value our relationship with you. The best relationships are those based on understanding, so we offer these methods for your services rendered.

- (A) You are responsible for payment in full for co-pay or deductible at each appointment as services are rendered unless arrangements have been made prior. We accept cash, checks with a valid driver's license, Visa or MasterCard.
- (B) As a courtesy to our patients, we accept most insurance carriers as an out of network provider, and we directly submit your claim. However, if we do not receive payment from your insurance company within 45 days of submission, you will be expected to pay for the balance on services rendered. We will promptly refund you payment once your insurance payment has been received.

We feel it is appropriate to clarify a possible misconception you may have regarding insurance company payment of claims. Most insurance companies do not pay 100% of the dental bill. In most cases, you the patient are responsible for the balance of the total bill. Each insurance company has different rules, regulations, and coverage guarantees. Your understanding of this will avoid surprises later.

Our office policy states that you are responsible for the total bill. We will gladly file your insurance claim as a courtesy. However, once the insurance claim has been paid, any balance left is your responsibility as the patient.

We will assist you in every way to understand the terms of your insurance coverage pertaining to dental services as well as our need for your bill to be paid in full within (30) thirty days of the issued bill.

- (C) Financial arrangements must be made prior to treatment.
- (D) Unpaid bills over (45) forty-five days are subject to collection fees. Return check fee is (\$30) thirty dollars per check, and we will not resubmit returned checks to the bank for payment.
- (E) All billing is processed by the last day of the month. Payments are due by the 15th of every month.

I have the right at any time to pay the unpaid balance due under any agreement. Payment hereunder is due on the date as set forth above, and late payments will be assessed a late charge at the rate of 18% per annum (1 1/2% per month) on the past due balance of the account. In the event the balance due is filed for collection under office policy, the responsible party will be liable for all attorney fees and costs in connection with same as well as late charges. The responsible party will also be responsible for all collection fees. Fees quoted are in effect for (90) ninety days. Fees are subject to change if treatment does not commence within 90 days.

We look forward to years of close association with you as we work together to maintain your dental health.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If signed by patient representative, state relationship to patient \_\_\_\_\_

Dr. Joseph G. Chiafair, D.D.S & Associates

AUTHORIZATION OF RELEASE AND ASSIGNMENT

I hereby authorize the release of X-rays or any information necessary for insurance, transferring of records, workman's compensation, collection, etc.

I assign all benefits from my dental insurance to Joseph G. Chiafair D.D.S., M.S. P.A. and Associates until cancellation in writing to the office.

I understand that I am responsible for all charges incurred and that the insurance contract is between myself and the insurance company. It is not the responsibility of Joseph G. Chiafair D.D.S., M.S. P.A. or Associates to collect from the insurance company. If we have agreed to accept assignment, the insurance company is given 30 days to pay, and then the balance not paid by insurance is due within 10 days. Payment is due when services are rendered unless special arrangements have been made prior to your appointment. If assignment of benefits has been accepted, you the responsible party, are required to pay your deductible and any portion the office feels the insurance will deny at the time of services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If signed by patient representative, state relationship to patient \_\_\_\_\_

Dr. Joseph G. Chiafair, D.D.S & Associates

HIPAA CONSENT FORM

I give this participating practice my consent to use or disclose my health/dental information to carry out my treatment to obtain payment from insurance company and for health/dental care operations.

I have been informed that I may review the practice notice of privacy practices (for a more complete description of users and disclosures) before signing the consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a description of how my protected health/dental information are used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction(s) they must follow the restriction(s).

I also understand that I may receive this consent at any time by making a request in writing, except for the information already used or disclosed.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If signed by patient representative, state relationship to patient \_\_\_\_\_