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PATRICIA GENNARO, D.D.S.

Date: \_\_\_\_\_

**PATIENT:**

(Mr., Mrs., Ms.) \_\_\_\_\_  
FIRST MI LAST

Date of Birth \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Home Address \_\_\_\_\_

CITY STATE ZIP CODE

Home Phone(\_\_\_\_) \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Marital Status \_\_\_\_\_ If Student  Full Time  Part Time  School \_\_\_\_\_

E-MAIL: \_\_\_\_\_ Preferred method of contact:  no preference  e-mail  
 text  phone call

**EMERGENCY CONTACT:**

FIRST AND LAST NAME MOBILE TELEPHONE NUMBER

Who has referred you to our office? \_\_\_\_\_  
FIRST NAME LAST NAME

What is the reason for your visit today? \_\_\_\_\_

**FINANCIAL INFORMATION**

PERSON RESPONSIBLE FOR YOUR ACCOUNT (GUARANTOR):

SELF  SPOUSE  MOTHER  FATHER  OTHER

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
FIRST NAME (IF DIFFERENT FROM ABOVE) LAST NAME

**INSURED PARTY**

Name: \_\_\_\_\_  
(IF DIFFERENT FROM ABOVE)

Address: \_\_\_\_\_  
CITY STATE ZIP CODE

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Name of Dental Insurance Company: \_\_\_\_\_  
CITY STATE ZIP

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Policy ID# \_\_\_\_\_ Group # \_\_\_\_\_

# MEDICAL HISTORY

ALL HEALTH HISTORY QUESTIONS ARE REQUIRED AND NEED TO BE FILLED OUT COMPLETELY.

Have you ever had any of the following? ONLY CHECK THOSE THAT APPLY:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Head Injuries           | <input type="checkbox"/> Radiation Treatment? | <input type="checkbox"/> Penicillin Allergy              |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Hepatitis               | Date: _____                                   | <input type="checkbox"/> LATEX Allergy                   |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> SULFA Allergy                   |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> NOVOCAINE Allergy               |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> Codeine Allergy                 |
| <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Joint Replacement       | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> OTHER PLEASE LIST               |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Stomach Problems     | _____  |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Stroke               | _____  |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Tuberculosis         |  |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Tumors               |  |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Atrial Fibrillation     | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> *NONE OF THE ABOVE!             |
| <input type="checkbox"/> Fainting           | <input type="checkbox"/> Currently Pregnant      | <input type="checkbox"/> Thyroid Problems     | <input type="checkbox"/> Currently use a Night Guard     |
| <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Chemotherapy Treatment? | <input type="checkbox"/> Fen-Phen/Redux       | <input type="checkbox"/> Currently use a Sleep Appliance |
| <input type="checkbox"/> Growths            | Date: _____                                      | <input type="checkbox"/> Osteoporosis         |  |
| <input type="checkbox"/> Hay Fever          |  |   |  |

1.) Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

2.) Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

3.) Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

4.) Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

5.) Has a physician - M.D. ever told you to take antibiotics prior to dental treatment?  Yes  No

6.) Do you, or have you ever taken Fosomax, Boniva, Reclast, Zometa or other osteoporosis drugs?  Yes  No

If so, WHEN? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

7.) Do you have jaw joint (TMJ) trouble? Clicking, popping, pain, limitation of opening?  Yes  No

8.) Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

9.) • Please list the names of ALL medications currently taking:

\_\_\_\_\_

## Financial Policy and Consent for Services

Please Read Carefully

If you have dental insurance, our office will work with you to maximize your allowable insurance benefits. It is understood that the dental treatment will be diagnosed based on your dental health and not your insurance coverage. It is further understood that since your insurance is a contract between you and your insurance company/employer, our practice cannot assume responsibility for coverage or other determinations made by your insurance company and that you will be responsible for timely payment for all treatment received from the practice regardless of your insurance status.

\*Payment, including insurance deductibles and co-pays for all treatment is due at the time services are rendered unless other payment arrangements have been made in advance. Co-pays are estimates based on the information provided by your insurance company.

If you fail to show for a scheduled appointment or cancel an appointment within less than 24 hours advance notice, a broken appointment fee of \$100 may be assessed to your account.

Returned checks and declined credit cards due to insufficient funds or otherwise will result in an additional fee added to the amount due on your account.

Payments for services may be made by cash, check, Care Credit, and all major credit cards including: Visa, Mastercard, Discover, Amex. These were arranged to reduce the financial barriers for our patients in receiving optimal dental care treatment.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period 90 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

To the best of my knowledge, all of the preceding answers above and all information provided on this form are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I have read the above consent of services and payment and agree to their content.

\*PRINT YOUR NAME\* \_\_\_\_\_ Date: \_\_\_\_\_

\*SIGNATURE \* \_\_\_\_\_

[of patient, parent, or guardian] MUST BE SIGNED.

## **PATIENT CONSENT FORM (HIPAA)**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
  - The day to day healthcare operations of your practice

We are required by law to maintain the privacy of your protected health information and to provide you with the notice of our legal duties and privacy practices with respect to protected health. This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above.

**\*PRINT YOUR NAME\*:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*SIGNATURE\*:** \_\_\_\_\_

**Signature of patient, parent, or guardian. MUST BE SIGNED**

## **Patient Advisory and Acknowledgment**

### **Receiving Dental Treatment During the COVID-19 Pandemic**

Dear Patient:

You have presented to our office today because you have an urgent dental condition which must be treated at this time and cannot be postponed until the current COVID-19 risk period abates. Please be advised of the following: While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees. Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus.

However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge. In order to reduce the risk of spreading COVID-19, we have asked you a number of “screening” questions below.

For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

- |  |           |
|--|-----------|
| 1.) Do you have a fever or have you felt hot or feverish recently (14-21 days)?                      | YES or NO |
| 2.) Are you having shortness of breath or other breathing difficulties?                              | YES or NO |
| 3.) Do you have a cough?   | YES or NO |
| 4.) Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?               | YES or NO |
| 5.) Have you experienced recent loss of taste or smell?  | YES or NO |
| 6.) Are you in contact with any confirmed COVID-19 positive patients?                                | YES or NO |
| 7.) Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders? | YES or NO |
| 8.) Have you traveled in the past 14 days out of the state or country?                               | YES or NO |

**PRINTED NAME:**

X \_\_\_\_\_

**SIGNATURE OF NAME/RESPONSIBLE PARTY:**

X \_\_\_\_\_

DATE