

Tell Us About Yourself

Patient's Name:	
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:	____/____/____ Age: _____
Today's Date:	
Home Phone:	
Home Address:	
City, State, Zipcode:	
Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Your Employer:	
How Long Employed:	
Social Security #:	Only required if you have no member ID on dental insurance
Work Phone:	
Are you a full time student?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person Responsible for Account:	
Name of Spouse (Parent if Minor):	
Patient Email Address:	
Patient Cell Phone:	
Emergency Info:	Name, Address & Telephone #
How did you hear about our office?	Google? Yelp? Facebook? Website? Instagram? Patient? (please circle) Other _____

DENTAL INSURANCE INFORMATION

Primary Carrier		Secondary Insurance	
Primary Insured's Name:		Primary Insured's Name:	
Date of Birth:		Date of Birth:	
Social Security #:		Social Security #:	
Insured's Employer:		Insured's Employer:	
Insurance Company:		Insurance Company:	
Insurance Co. Address:		Insurance Co. Address:	
Insurance Phone #:		Insurance Phone #:	
Insurance Group #:		Insurance Group #:	
Insurance ID#:		Insurance ID#:	

TELL US ABOUT YOUR TEETH & DENTISTRY

Are you experiencing any of the following:

Tooth Sensitivity (hot, cold, sweet)

Where: UR LR UL LL

Headaches, earaches, neck pain

Jaw joint pain

Teeth or fillings breaking

Grinding or clenching teeth

Bleeding, swollen or irritated gums

Loose, tipped or shifting teeth

Bad Breath

If you could change your smile, would you...?

Make them whiter?

Make them straighter?

Close Spaces?

Repair chipped teeth?

Replace missing teeth?

Replace old crowns that don't match?

Replace black metal fillings?

Have a smile makeover?

Do you have or have you had any of the following?

Dentures

Partial Dentures

Braces

Periodontal (Gum) Treatment

Date of Last Cleaning:

Date of Last Oral Cancer Screening:

Date of Your Last Complete X-Rays:

Name of Last Dentist:

Phone & Address of Last Dentist:

Why did you leave your previous dentist?

Did you smoke or use chewing tobacco?

How much: How long:

On a scale from 1 -10 (10 being the highest):

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

How do you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

What can we do to make your experience here as pleasant and stress-free as possible?

What is the most important thing to you about your dental visit today?

What is the most important thing to you about your future smile and dental health?

MEDICAL HISTORY

Patient Name: _____

Please check the boxes of the following which apply to you:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Bruise/Bleed Easily | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Lupus/other Autoimmune | <input type="checkbox"/> Currently Nursing |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Bone Density | <input type="checkbox"/> Seizures | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cancer | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Radiation(Head/Neck) | <input type="checkbox"/> Tobacco Habit | <input type="checkbox"/> Other: |

PLEASE LIST ALL ALLERGIES:(ANY DRUGS, MEDICATIONS,LATEX,FOODS, METALS, JEWELRY,PLASTICS, ACRYLICS)

Are you under a physician's care? Yes No

What for: _____

Family Physician: _____

Phone: _____

Have you been hospitalized or had any in-patient or out-patient surgeries in the past five years?

No Yes, explain _____

LIST ALL MEDICATIONS, PILLS, VITAMINS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Patient Signature (or Parent/Guardian): _____

Date: _____

Doctor Signature: _____

Date: _____

Date: _____ Changes: _____ Patient Initial: _____ Doctors Signature: _____

Da : _____ Changes: _____ Patient Initial: _____ Doctors Signature: _____

ate:: _____ Changes: _____ Patient Initial: _____ Doctors Signature: _____

NOTICE OF PRIVACY NOTICE – WRITTEN PERMISSION

There's been a development in the health industry that requires us to get your written permission in case we ever need to share your treatment information with a specialist, dental lab, or an insurance company. When you sign this form, you give us your approval to share your treatment information and you acknowledge that you are aware of our potential need to do so.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices. I also give my permission should it be necessary to share my treatment information. A copy of this notice and acknowledgement will be kept in my Patient file.

You may refuse to sign this acknowledgement. However, without your signature, we cannot file your insurance or treat you today.

Please Print your Name:

Patient Signature:
Date:

For Office Use Only (Patients should not write below this line):

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify):

WE RESERVE THE RIGHT TO REFUSE FUTURE APPOINTMENTS FOR NO-SHOWS AND LATE CANCELLATIONS

OUR FINANCIAL INFORMATION

- Payment is due at the time service is provided. Our office accepts **cash, personal checks, MasterCard, Visa, American Express and Discover**. Outside financing is available upon request and approval.
- **Please check if you would like more information about financing options.**
- **Please Note:** Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal services, you will be responsible for any collection and/or legal charges incurred up to 35%.

NO SHOW FEE or Less than 48 hours cancellation Fee will be charged of \$75.00

In today's insurance market, many patients have lost the ability to choose their own dentist! While Dr. Tarantola is not on any specific provider lists, he serves many patients as an "out-of-network" dentist.

Being in-network severely limits the ability to tend to the extra details necessary to provide dentistry in a holistic way.

We will file your claim for you and help you receive the entire benefit due to you under the terms of your plan.. Since patients value Dr. Tarantola's approach to dentistry, many have opted out of their networks to come see Dr. Tarantola. We will gladly assist you in determining your coverage.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MYSELF, THE PATIENT.

Consent: The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. All procedures, tests and treatments will be fully explained to your satisfaction before anything is done.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

PATIENT SIGNATURE (Parent of Child): _____ DATE: _____