

Welcome! Thank you for selecting our Dental Team!

Please complete the following confidential information form.

PATIENT INFORMATION

Patient's Name: _____ Middle Initial: _____ Date of Birth: _____
 Preferred Name: _____ Male Female
 Soc. Sec. # _____ - _____ - _____ Driver's License # _____
 Address: _____
 City: _____ State: _____ Zip: _____ Home Phone # (_____) _____
 Cell Phone # (_____) _____ Email: _____
 Employer: _____ Employer Phone # (_____) _____
 May we contact you at work? Yes No
 If patient is a minor, parent's names: _____ Phone # (_____) _____
 Name of nearest relative not living with you: _____ Relationship: _____
 Complete Address of Nearest Relative: _____
 City: _____ State: _____ Zip: _____ Phone # (_____) _____
 Emergency Contact: _____ Relationship: _____ Phone # (_____) _____
 We like to thank those who refer new patients. How did you hear about us?
 Friend/Neighbor/Family Name: _____ TV Yellow Pages Google
 Other: _____
 Are you available for appointments on short notice? Yes No
 Preferred method of contact: Home Phone Cell Phone Work Phone Email

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

Relationship to Patient: _____ Name: _____ Birth Date: _____
 Soc. Sec. # _____ - _____ - _____ Driver's License # _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone # (_____) _____ Work Phone # (_____) _____ Cell Phone # (_____) _____
 Employer: _____ Employers Phone # (_____) _____

DENTAL INSURANCE INFORMATION

Primary Subscriber's Name: _____ Subscriber's Soc. Sec. # _____ - _____ - _____
 Insurance Company: _____ Phone # (_____) _____ Group # _____
 Date of Birth: _____ Employer: _____
 Secondary Subscriber's Name: _____ Subscriber's Soc. Sec. # _____ - _____ - _____
 Insurance Company: _____ Phone # (_____) _____ Group # _____
 Date of Birth: _____ Employer: _____

**Please provide us with a copy of your Dental Insurance Cards*

PLEASE TELL US ABOUT YOUR SMILE

How would you describe your current dental condition?

Are you interested in a lifetime strategy for complete dental care? Yes No Is it important for you to keep your teeth for life? Yes No

Would you like your teeth to be: (check all that apply)

More White? More Straight? No Gaps/Holes in Smile? No Decay/Fractures? Are you having pain or discomfort at this time? Yes No Does dental treatment make you nervous? No Slightly Moderately Extremely

Former Dentist Name: Phone # (.....)

Last dental examination date: Last dental cleaning date:

MEDICAL INFORMATION (CONFIDENTIAL)

1 Physician's Name: Phone # (.....)

2 Have you been hospitalized in the past two years? Yes No 3 Do you have difficulty breathing while lying down? Yes No 4 Have you ever taken Fen-Phen or Redux to help you lose weight? Yes No

5 Please list the names of any medications (including over the counter)

6 Has any physician ever told you that you need an antibiotic prior to dental treatment? Yes No

Please explain below:

7 Do you use tobacco in any form Yes No If yes, what and how much?8 Are you sensitive/allergic to any medications? Yes No If Yes, describe below:
9 Are you taking or scheduled to begin taking either of the medications, alendronate (Fosomax®) or risedronate (Actone®) for osteoporosis or Paget's disease? Yes No 10 Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia®) or Zometa® for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease multiple myeloma or metastatic cancer? Yes No Date Treatment Began:11 Do you have any implants, transplants, or joint replacements? Yes No Please explain below:
12 Are you currently pregnant, nursing, or planning to become pregnant? Yes No

MEDICAL INFORMATION (CONFIDENTIAL) CONTINUED:

13 Indicate which of the following you have or have ever had. Check Yes or No

	Yes	No		Yes	No		Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack/trouble	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Radiation/Chemo Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Birth Control	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, C	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Tumors/Growths	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers/Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Metal Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

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

	Yes	No	Teeth	Yes	No
Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding, sore gums	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to hot/cold/sweets	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath/unpleasant taste	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to biting	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters	<input type="checkbox"/>	<input type="checkbox"/>	Food impaction	<input type="checkbox"/>	<input type="checkbox"/>
Ortho treatment	<input type="checkbox"/>	<input type="checkbox"/>	Clenching/grinding	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaw	<input type="checkbox"/>	<input type="checkbox"/>	Shifting of teeth	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	Teeth ground down or adjusted	<input type="checkbox"/>	<input type="checkbox"/>
Bite plate or mouth guard	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

15 Do you use the following, and how often?

	Yes	No	How often
Toothbrush	<input type="checkbox"/>	<input type="checkbox"/>	
Dental floss	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride rinse	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient's Signature: Date:

Doctor's Signature: Date:

FINANCIAL POLICY - MOORE & PASCARELLA, A DENTAL GROUP

We are pleased that you have chosen us for your dental needs. We look forward to a long and continuous relationship. In order to better serve your needs, we offer the following information concerning our Financial Policy:

Payment is due in full at the time of visit. Discount incentives are offered for cash or check amounts of treatment over \$500. Applications for CareCredit and Chase Health Advance are also available at the office and on our website mooreandpascarella.com. Many times, treatment can be financed, interest free, through these finance companies. We allot a specific amount of time for each procedure. Should you need to change an appointment, we ask that you give our office 48 hours notice. Failure to keep your appointment may result in a \$65.00 failed appointment fee. Our office accepts the following methods of payment for services rendered:

- CASH
- TRAVELERS CHECKS
- DISCOVERY CARD
- PERSONAL CHECKS
- AMERICAN EXPRESS
- CARE CREDIT
- MOST ATM CARDS
- VISA
- CHASE HEALTH ADVANCE
- MONEY ORDERS
- MASTER CARD

INSURANCE INFORMATION

At each visit, insurance co-pays are estimated by our Financial Coordinator. We base estimates upon limited information provided to us by your insurance company. You will be asked to pay your estimated co-pay at each visit. If there is a residual balance following insurance payment, you will be billed and will be responsible for that amount. All amounts are due in full within 60 days from date of service, regardless of insurance.

While we do our very best to estimate your insurance co-pays, we have no contractual agreement with your insurance company and have no control over their decision-making process. Your insurance contract is between your employer and your insurance company, and it has been purchased for you by your employer.

If you do not agree with the insurance company's decision, we will help you with the appeal process, however we ask you to follow up fully with your carrier to expedite payment if insurance does not pay within 30 days. We also ask that you make payment in full, if insurance has not paid after 60 days from date of service. Following insurance payment, you will be reimbursed for any credit on your account.

If you have any questions, please do not hesitate to contact our Financial Coordinator or Office Manager. We welcome you to our dental family and look forward to seeing you at your next visit.

I HAVE RECEIVED AND FULLY UNDERSTAND THE FINANCIAL POLICY FOR THE OFFICE OF MOORE & PASCARELLA, A DENTAL GROUP. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES REGARDLESS OF INSURANCE DECISION. I UNDERSTAND THA CO-PAYS ARE DUE AT EACH VISIT.

Responsible Party Signature: Date:

Witness: Date:

AUTHORIZATION TO RELEASE DENTAL INFORMATION

I hereby authorize any associate of Moore & Pascarella Dental Group to release any and all dental information to process my insurance claim.

Signature: Date:

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to pay directly to Moore & Pascarella Dental Group all dental benefits due me, by reason of services described in the statements rendered and the above policy contract with the aforementioned insurance company. I understand I am financially responsible to the dentist for charges not covered by this authorization.

Signature: Date:

AUTHORIZATION TO CONTACT CELL PHONE

I consent to the dental practice using my cell phone number to (choose one or both) call or text regarding appointments, and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) (.....)..... Initial:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Moore & Pascarella's [privacy practices](#).

Signature: Date:

CONSENT

1 The undersigned hereby authorized doctor to order x-rays, study models, photographs or any other diagnostic aids deemed appropriate medication and therapy to make a thorough diagnosis of the patient's dental needs.

2 I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with:

Name of Patient: I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3 I understand that all 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 other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account, in addition to any collection charges.

4 I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Signature: Date: