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, alendratonate (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 metastic 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			Head Injuries			Pacemaker		
Arthritis			Heart Disease			Respiratory Problems		
Artificial Joints			Heart attack/trouble			Psychiatric Treatment		
Asthma			Heart Murmur			Radiation/Chemo Treatment		
Birth Control			Hemophilia			Rheumatic Fever		
Blood Transfusions			Hepatitis A, B, C			Rheumatism		
Cancer			High Blood Pressure			Sinus Problems		
Chest Pain			HIV+/AIDS			Stroke		
Diabetes			Jaundice			Thyroid Problems		
Dizziness/Fainting			Kidney Trouble			Tuberculosis		
Drug Addiction			Latex Allergy			Tumors/Growths		
Emphysema			Liver Disease			Ulcers/Stomach Problems		
Epilepsy/Seizures			Migraines					
Glaucoma			Metal Sensitivity					
Hay Fever			Mitral Valve Prolapse					

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

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

15 Do you use the following, and how often?

	Yes	No	How often
Toothbrush			
Dental floss			
Fluoride rinse			
Other			

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: .....