Welcome to our office!

Patient Information

Name_____Today's Date_____

Address _____Apt. #_____

City _____State _____ Zip_____

Date of Birth _____Age _____Social Security #_____

Home Telephone # _____Cell phone # _____

Marital Status _____ Email Address _____

Employment Information (If patient is a minor, use parent's information.)

Occupation_____Employer_____

Business Address_____ Business Telephone # _____

Medical Information

Current Dentist_____ Phone #_____

Current Physician _____ Phone #_____

In Case of an Emergency

Contact _____Phone _____Relation_____

Dental History

Why have you come to the office today? _____

Are you in pain today? Yes…No Have you experienced unusual bleeding in the past?…Yes…...No

Do you experience pain, clicking, and/or popping of the TMJ?....Yes…...No

If you answered "Yes" to any of the questions above, please explain: _____

_____

1983 Crompond Rd, Suite 101 Cortlandt Manor, NY 10567
(914) 736-3343

PHARMACY _____

Medical History

1. Are you in good health?…….Yes……No

2. Have there been any changes in your health status over the past year?….Yes……No

3. When was your last physical exam? _____

4. Please circle **yes/no** if you have been diagnosed or treated with any of the following:

Heart Disease…….....yes/no	Asthma……..... yes/no	Diabetes…….....yes/no
Heart Murmur.....yes/no	Emphysema/COPD.....yes/no	Glaucoma.....yes/no
High/Low Blood Pressure…. yes/no	Stomach Ulcer…….yes/no	Seizures……yes/no
Heart Attack/Angioplasty….. yes/no	Immune Suppression…...yes/no	Cancer/Malignancy….. yes/no
Acid reflux/GERD……..... yes/no	Thyroid disorder……..yes/no	Substance Abuse……..yes/no
Stroke/TIA…… yes/no	Hip/Joint Replacement…… yes/no	Bleeding disorder…….yes/no
Rheumatic Fever…… yes/no	Kidney Disease…….. yes/no	Pacemaker.....yes/no
Liver Disease……..…. yes/no	Angina/chest pain……..yes/no	Arthritis.....yes/no
Endocarditis…….... yes/no	Depression……..…. yes/no	Anemia……....yes/no
Psychiatric Disorders…..... yes/no	Chemo/radiation……..yes/no	Blood Transfusion……..yes/no

Other medical condition not listed above :

_____

5. Do you have **allergies** to medications or food?……..……Yes……No

If yes, please list_____

6. Please list all **medications** you are taking. Please include over-the-counter and herbal medications:

_____

7. Are you taking, or have you ever taken Bisphosphonates (Fosomax, Aredia, Zometa, or Actonel)

for osteoporosis or any reason?……..……..……..Yes……No

8. Do you smoke cigarettes?……Yes…….No If yes, how much per day?_____

9. Have you or a family member had any problem with intravenous or general anesthesia?….Yes……..No

For Women Only

1. Are you pregnant, or is there a chance you are pregnant?…….....Yes……No

2. Are you nursing?…….....Yes……No

If you are using oral contraceptives (birth control pills), it is important that you understand that antibiotics may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use alternative forms of birth control for one complete cycle of birth control pills, after the course of antibiotics is completed. Please consult with your physician for further guidance and recommendations.

_____

Signature of Patient (Guardian) Print Name Date

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Financial Information

Who is Person Responsible for this Bill **(not the insurance name)**?_____

I will be paying today by **(circle one)**: **Cash Check Mastercard/Visa Discover Card AMEX**

Do you have Dental Insurance: ____ Yes ____ No, I do not have insurance

Regarding Insurance

If the office participates in your dental plan, you are ultimately responsible for the full authorized amount for services according to your plan, whether or not the insurance company makes any payment on your claim. Any dispute over amounts paid or charges allowed is between you and your insurance company. There will be a surcharge for any amounts overdue if taken to collections and the surcharge will be the amount charged by collections, bank fees and legal fees.

Thank you for understanding our financial policy. I have read, understand, and agree to the above financial policy.

Patient Signature_____

Consent

I understand the information I provide on this form is essential to determine my dental needs, and the information given today is correct and truthful to the best of my knowledge. It will be my responsibility to update the office as changes to my health history occur.

_____

Signature of Patient (Guardian) Date

Patient HIPAA Awareness

With my permission, Dr. Del Vecchio may use and disclose protected health information (PHI) about me to carry out treatment, payment and health-care operation (TPO). Please refer to Dr. Del Vecchio Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Del Vecchio reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Del Vecchio may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Del Vecchio restrict how he uses or discloses my PHI to carryout TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Del Vecchio to use or disclose my PHI for TPO. I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent.

_____

Signature of Patient (Guardian) Print Name Date

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PATIENT DISCLOSURE

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. Part of your treatment may include photographs taken of you by our office for treatment, educational, and/or advertising purposes.

_____

INFORMED CONSENT TO PHOTOGRAPH

Date:_____

I, _____, due hereby give consent for Dr. Del Vecchio or staff to take and/or display photograph(s) of the face and teeth/smile of_____

(Patient's Name)

The photograph will be used for educational purposes by Dr. Del Vecchio on either the dental office's webpage, www.yorktownoralsurgeon.com and/or our social media channels. The doctor and staff will protect the patient's personal data, such as name, age and date of birth, from being displayed.

Print Name:_____ Signature:_____

Relation to Patient:

_____Self _____Guardian