**Section 1** **Patient Information**

Name:_____ Name I Prefer to be called(nickname):_____

Date of Birth:_____ Social Security Number:_____ ☐ Male ☐ Female

Address:_____City:_____State:_____Zip_____

Phone (_____)_____ Cell (_____)_____ Work (_____)_____

Email: _____ We will be using cell and/or email to confirm appointments.

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married Name of Spouse:_____
Is spouse a patient with this office: ☐ Yes ☐ No

Employer name & address: _____

If Student, Name of School_____ City/State_____ ☐ FT ☐ PT

If Minor, List Parents' Names: Mother_____ Father_____
Is mother a patient with this office: ☐ Yes ☐ No Is father a patient with this office: ☐ Yes ☐ No

**Section 2** **Person Responsible For Bill**

Relationship to Patient: ☐ Self (skip to sec 3) ☐ Spouse ☐ Parent ☐ Other_____ Is this person a patient? : ☐ Yes ☐ No

Name:_____DOB:_____SS#:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Employer:_____ Dental Insurance: ☐ Yes ☐ No (If YES, please complete info on back of form)

**Section 3** **Medical History**

| | | | |
|---|---|---|---|
| ☐ Allergies (seasonal) | ☐ Heart Disease | ☐ Osteoporosis | ☐ Penicillin Allergy |
| ☐ Anemia | ☐ Heart Valve Replacement | ☐ Radiation Treatment | ☐ Codeine Allergy |
| ☐ Asthma | ☐ Hepatitis | ☐ Sinus Problems | ☐ Tetracycline Allergy |
| ☐ Arthritis | ☐ High Blood Pressure | ☐ Stomach Problems | ☐ Erythromycin Allergy |
| ☐ Blood Disease | ☐ Jaundice | ☐ Stroke | ☐ Aspirin Allergy |
| ☐ Blood Thinner Medication | ☐ Joint Replacement | ☐ Tuberculosis | ☐ Sulfa Drug Allergy |
| ☐ Cancer, type:_____ | list:_____ | ☐ TMJ Discomfort | ☐ Latex Allergy |
| ☐ Chemotherapy | ☐ Kidney Disease/Disorder | ☐ HIV/STD | ☐ Other Med Allergy: |
| ☐ Cold sores | ☐ Liver Disease/Disorder | ☐ Smoke | list: _____ |
| ☐ Diabetes | ☐ Nervous Disorder | ☐ Tobacco (chewing) | _____ |
| ☐ Excessive Bleeding | ☐ Pregnant (currently): | ☐ Other Medical Issues: | _____ |
| ☐ Grind Teeth/Clench Jaw | due date:_____ | list:_____ | _____ |

**Other Medical Conditions or Procedures:**_____

**List of medication currently taking:** _____

_____**Preferred Pharmacy**:_____

Information given is held in the strictest of confidence. "To the best of my knowledge, all of the preceding answers and information provided are true and accurate"

**Signature**_____ **Date**_____

***PLEASE COMPLETE & SIGN THE NEXT PAGE ====➔***

**Section 4** **Dental Insurance Information**

DO YOU HAVE **DENTAL** INSURANCE: ☐ Yes ☐ No *******Please provide Dental Insurance Card(s) for copying******

Name of Subscriber_____Relationship to Patient _____

Subscriber's DOB:_____ Subscriber's SS#:_____

Name of Employer:_____ Work Phone: (_____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ ID #_____ Group#_____

Ins Co Address:_____ Ins Co. Phone:_____

*******DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING**

Name of Sucscriber_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp#_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

**Section 5** **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (**you may refuse to sign)

I have received a copy of this office's Notice of Privacy Practices.

_____ Is patient a minor? _____

(Print name of PATIENT)

_____ Check here if refusing to sign: _____

(Signature of PATIENT or legal guardian of minor)

**Section 6** **CONSENT FOR SERVICES**

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Our office accepts cash, checks, money orders, Visa, Mastercard, Discover and Care Credit ®Patients who carry dental insurance understand that all dental services furnished are charged to the patient and that he or she is personally responsible for payment of all dental services. As a courtesy, this office will submit the patient's insurance forms and will credit any payments to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand that I am responsible for any payments for services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor or his assignee, at the time said services are rendered. A monthly service charge at a fixed rate of 2% per month (24% A.P.R.) of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. In consideration for the professional services rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission charged by the collection agency to whom a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary. I understand that any rescheduling of my appointments must be made at least 24 hours prior to the appointment date and that if I fail to cancel any appointment at least 24 hours prior to, this office reserves the right to charge me a missed appointment fee of a minimum of $40.00 per scheduled hour. This fee must be paid in full before any further appointments can be scheduled. I grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form, including account & appointment reminders. I also hereby authorize said assignee to release all information necessary to secure payment. I hereby assign all dental benefits, including private insurance and other health plans to: Thomas Matanzo, DDS, Inc. This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I have read and understand the above conditions of treatment and payment and agree to their content.

**Signature**_____ **Date**_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

***PLEASE COMPLETE & SIGN THE LAST PAGE ====➔***

**Authorization to Discuss Medical Information**

Patient Name: _____ Date of Birth:_____

I hereby authorize you to disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed (**check all that apply**):
□ Appointment Date/Times
□ Diagnosis
□ X-ray Results
□ Medications
□ Summary of Dental/Medical Record
□ Treatment Plan
□ Other (specify): _____

Information to be given to (list names of all people):

Name:_____ Relationship to patient: _____

Name:_____ Relationship to patient: _____

Name:_____ Relationship to patient: _____

Name:_____ Relationship to patient: _____

This authorization shall remain in effect from the date signed below until (please check one):

□ **NO EXPIRATION DATE**

□ **(specify expiration date or event)_____**

## IF YOU DO NOT WISH TO DESIGNATE ANYONE, SIMPLY SIGN & DATE AT BOTTOM

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving Thomas Matanzo, DDS, Inc, the right to discuss my medical/dental information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.

Signature: _____Date: _____

Relationship to Patient (if person completing this form is not the patient):

_____