Welcome to the Dental office of Dr. Joseph Spina. We understand there are a lot of choices in dentistry today and we really appreciate the confidence you show in trusting us with your dental health.

--Personal Information---

Name:___________________________________Date:___________________________

Gender: Male Female Home Phone: _______________

Date of Birth: _________________ Business Phone: __________________

Occupation_____________________________ Cell Phone: ______________________

Home Address:____

Spouse's Name:______________________________ Phone #____________________

Emergency Contact:___________________________ Phone #____________________

Email Address: ___________________________

We can contact you via email and text message to confirm appointment times. Would you like us to do that to the above cell number and email address? **Yes/No**

8 out of 10 of our new patients are referred from our existing patients. **Who can we thank for your referral?**____

--------------------------------Insurance Information-------------------------------

Name of Insured:________________________ **Relationship to insured: Self / Spouse / Child / Other**

Insured Social Security Number:___________ **Insured Birth Date:**_________________

Employer Name:________________________ **Dental Insurance Company:**_______________________

Employer Address:____

--Appointment Information--

What is the purpose of your visit with us today?

Are you having any dental problems you would like Dr. Spina to address?

--------------------------------Dental History--

Please select **ONE** statement from each of the following sets:

My mouth is very comfortable **/** My mouth is moderately comfortable **/** My mouth is uncomfortable

My smile is excellent **/** I would like to change my smile **/** I am uncomfortable with my smile

I will do whatever I must to keep my teeth **/** I want to keep my teeth but only with a certain budget of time and money

I've done all the dentistry recommended to me **/** I've NOT done the dentistry recommended **/** none has been recommended

------------------------------Dental Expectations-----------------------------------

My dental health is EXCELLENT **/** GOOD **/** FAIR **/** POOR

From the list below, circle **any** statement that describes any **obstacles** you believe will prevent you from achieving your dental health goals:

I see no obstacles **/** time away from work and other obligations **/** fear of pain or injections **/** fear because of previous dental experience **/** the cost of treatment

---Medical History---

Please List the **ALL MEDICATIONS** you are currently taking:

Please List **ALL MEDICATIONS and FOODS** you are allergic to:

Do you have an artificial or prosthetic Joint? **Yes/No** When was it placed?

Has your prosthetic ever been infected? **Yes/No**

Do you have an artificial heart valve? **Yes/No**

For the following questions, **circle Yes or No**. Your answers are for our records only and will be kept confidential.

1. Are you in good health........................Yes No

2. Has there been any change in your general health within the past year? .... Yes No

Have you ever had or do you now have?

3. Pacemaker .... Yes No

4. Heart Murmur .... Yes No

5. Mitral valve prolapse .... Yes No

6. Rheumatic heart disease .... Yes No

7. Damaged or prosthetic heart valve .... Yes No

8. Heart trouble .... Yes No

9. Heart attack .... Yes No

10. Angina .... Yes No

11. High Blood Pressure .... Yes No

12. Arteriosclerosis) ……Yes No

13. Stroke .... Yes No

14. Chest pain upon exertion .... Yes No

15.Shortness of breath after mild exercise or when lying down? .... Yes No

16. Swollen ankles .... Yes No

17. Congenital heart defect .... Yes No

29. TB, Tuberculosis (Self, Family, Household) …… Yes No

30. Persistent cough/ cough that produces blood … Yes No

31. Arthritis or painful/swollen joints .... Yes No

32. Artificial joint replacement .... Yes No

33. Stomach ulcer or hyperacidity …... .... Yes No

34. Kidney trouble or dialysis .... Yes No

35. Persistent swollen glands in neck .... Yes No

36. Sexually transmitted disease .... Yes No

37. Epilepsy or other neurological disease ....Yes No

38. Psychotherapy .... Yes No

39. Problems with mental health .... Yes No

40. Cancer .... Yes No

41. Problems of the immune system .... Yes No

42. Rheumatic fever or scarlet fever .... Yes No

43. Abnormal bleeding .... Yes No

44. Blood transfusion .... Yes No

45. Blood disorders such as anemia................. Yes No

46. Tumor or growth .... Yes No

47. Allergic or other reaction to

a. local anesthetics............................ Yes/No

18. Prosthetic (artificial) heart valve …………… Yes No

19. Allergy ………………………………………… Yes No

20. Sinus trouble ………………………………… Yes No

21. Asthma or hay fever ……………………….. Yes No

22. Fainting spells or seizures ………………….. Yes No

23. Persistent diarrhea or recent weight loss …… Yes No

24. Diabetes ………………………………………… Yes No

25. Hepatitis, jaundice or liver disease …………. Yes No

26. AIDS or HIV infection ……………………….. Yes No

27. Thyroid problems …………………………….. Yes No

28. Respiratory problems, emphysema,

bronchitis, etc. …………………………………….. Yes No

b. Penicillin or other antibiotics ………………...Yes No

c. Sulfa drugs ………………………………………….Yes No

d. Latex………………………………………… ………….Yes No

e. Aspirin …………………………………………………Yes No

f. Codeine ………………………………………………..Yes No

g. Other ……………………………………………….... Yes No

Women

48. Are you pregnant?................................. Yes No

49. Do you have any problems associated with your

menstrual period? ……………………………......... Yes No

50. Are you nursing?. ……………....……………… Yes No

Please explain YES answers above and list serious illnesses, operations and hospitalizations within past five years:

Are you now under the care of a doctor? Yes No If Yes, what is the condition being treated?

I certify that I have read and understood the above. I acknowledge that any questions I had about the inquiries above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any errors that I may have made in the completion of this form.

____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN Date

Office Policies

Dear Patient,

We would like to take the time to update and review with you some of our office policies.

Payment for Services:

We are constantly searching for ways to maintain our high standards of patient care and emergency access while controlling additional expense to our patients.

Payment will be due at the time service is rendered. Prior to your appointment our office can give at your request an estimate of the payment due. If you have dental insurance for which we are a participating provider a portion of your visit may be covered by your insurance company. In this case, an estimated copayment will be due at time of service. If your insurance company does not pay the expected amount, the balance will be due by the patient within a 15 day net term. We do offer financing though a medical finance company called Care Credit. Our staff will be happy to explain this option to you.

As a service to our patients who wish to utilize insurance benefits from companies for whom we are not a participating provider, we will submit all necessary documentation and radiographs to your insurance company and file all paperwork required. Insurance benefits will be sent directly to the patient. The patient will be reimbursed directly from his/her insurance company. The amount of the benefit will be determined by your insurance contract.

HIPPA:

We follow all the HIPPA protocols set out by the American Dental Association. Our HIPPA policy is available upon your request from our office manager. Our HIPPA policy is updated yearly by the ADA and a new copy will be available to you yearly.

X________________ **Initial Here**

Broken Appointment Fee

Every one has to break appointments now and then. However, we require 2 business days advance notice be given. That way you and your doctor's time can be more efficiently

utilized . In order to discourage last minute cancellations, the office policy requires a charge of $50.00 for a hygiene appointment and $100.00 for Dr. Spina's appointments after the first broken appointment. The fees cover a portion of our overhead.

Consent for Treatment:

I hereby authorize a general dental exam, periodontal exam, and any treatment necessary as related to the dental care of the patient whose name appears on the attached health history form. I grant authority to administer local anesthetics, take radiographs, perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I understand that there are possible adverse effects to the procedures, anesthetics, and/or drugs to be employed.

I authorize the release of any information relating to claims for the above listed persons to an insurance company designating them, if applicable, and authorize insurance payments to be released to Joseph Spina III, D.M.D.

I fully understand and agree to the above policies.

____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN Date