Cicero Family Dentistry

Date: _____ Confidential Medical and Dental History

Patient Name: _____ _____
Last First MI Prefer to be called

Gender: _____ Social Security #: _____-_____-_____ Birthdate: ____ /____ /_____

Parent/Guardian Name(s) (if applicable): _____

Preferred Phone #: _____ Type: _____ Alt #: _____ Type: _____

Address: _____
Street Apartment #

_____ Email Address: _____
City State Zip Code

Employer: _____ Occupation: _____

Emergency Contact: _____ Emergency Contact #: _____
Name Relationship

Whom may we thank for referring you to our office? _____

Health Information

Date of last physical: _____ Physician Name: _____

Have you been hospitalized in the past two years? ☐ Yes ☐ No If yes, please explain: _____

_____

Do you have or have you had any of the following? Please check all that apply:

☐ Allergies: _____

☐ Acid Reflux / GERD	☐ Autoimmune Disorder	☐ Asthma	☐ Do you have artificial joints? Year(s)_____
☐ Difficulty Swallowing	☐ HIV+ / AIDS	☐ Respiratory Issues	
☐ Digestive Problems	☐ Tuberculosis	☐ Sinus Problems	
☐ Anemia	☐ Alcohol Dependency	☐ Cancer / Chemo / Radiation	☐ Have you ever taken any Bisphosphonates? (meds for osteoporosis) Which? _____
☐ Blood / Bleeding Disorder	☐ Mental Health Problems	☐ Diabetes	
☐ Blood Thinners	☐ Dizziness	☐ Kidney Disease	
☐ Heart Attack	☐ Head Injuries	☐ Liver Disease / Hepatitis	
☐ Heart Disease	☐ Seizures	☐ Thyroid Problems	☐ Are you pregnant? Due Date: _____
☐ High Blood Pressure	☐ Stroke		☐ Nursing?
☐ Pacemaker			

☐ *Please check here if none of the above conditions apply to you*

Are you presently taking any medications? ☐ Yes ☐ No Preferred Pharmacy: _____
Name Location

If yes, please explain *(please provide separate list if medications do not fit in allotted space)*:

_____

_____

_____

Are you currently being treated for any ongoing medical conditions? ☐ Yes ☐ No

If yes, please explain: _____

Name of physician(s): _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

Do You use tobacco products? ☐ Yes ☐ No How Long? _____ How much? _____

Do you experience difficulty swallowing? ☐ Yes ☐ No

Dental History

Purpose of this dental visit: _____

Date of last dental exam: _____ Date of last x-rays: _____

☐ Yes ☐ No Are you having pain or discomfort at this time?

☐ Yes ☐ No Are you very nervous about having dental treatment?

☐ Yes ☐ No Have you ever had a bad experience in a dental office? If yes, please explain:

_____

☐ Yes ☐ No Have you ever had complications following dental treatment? If yes, please explain:

_____

☐ Yes ☐ No Do you feel like you have dry mouth?

☐ Yes ☐ No Are there any growths or sores in or around your mouth?

☐ Yes ☐ No Do you have trouble chewing?

☐ Yes ☐ No Does food catch between your teeth?

☐ Yes ☐ No Do you have bleeding gums or any other gum condition?

☐ Yes ☐ No Have you ever been told you have gum problems?

☐ Yes ☐ No Do you have pain in or near your ears?

☐ Yes ☐ No Do you habitually clench or grind your teeth during the day or night?

☐ Yes ☐ No Do you dislike the color of your teeth?

☐ Yes ☐ No Do you dislike the shape or spacing of your teeth? If yes, please explain:

_____

☐ Yes ☐ No Do you have old dental work you do not like looking at? If yes, please explain:

_____

What would you like to change the most about the appearance of your teeth, if applicable?

_____

☐ Yes ☐ No Do you snore?

☐ Yes ☐ No Have you been tested for sleep apnea?

☐ Yes ☐ No Have you been diagnosed with sleep apnea?

☐ Yes ☐ No Do you currently wear any sleep apnea appliances?

Source of water: ☐ well ☐ city/public

Consent for Treatment and Financial Arrangement

To the best of my knowledge, all of the information on both sides of this form is true and correct. If there is any change in my health or my medications, I will inform the doctor prior to any treatment.

I authorize the Doctors and/or their staff to treat the above named patient. I will contact the Doctors' office if I have any additional questions or there are any unexpected reactions to treatment. I realize that the results of certain procedures cannot be guaranteed.

All financial arrangements will be made prior to treatment. I realize that ultimately, I am completely responsible for payment of all treatment. The office will assist by filing all necessary insurance paperwork for me.

I realize that the fee estimate listed for dental care is only valid for six months.

I have read and fully understand the conditions of treatment as stated.

☒ **Signature** _____ **Date** _____

Cicero Family Dentistry

6221 RT 31 STE 102
Cicero NY 13039

Authorization for Use and Disclosure of Health Information

Patient Name: _____ DOB: _____/_____/_____

It is our intent to protect the confidential nature of your protected healthcare information. Personal and clinical information are not given to vendors or other institutions without your express consent of such as follows.

Please review and <u>initial</u> the following releases of Protected Healthcare Information:

_____ initial 1. I authorize appointment confirmations (and if applicable necessary pre-medication reminders) by postcard, text message, and/or voicemail/message systems at the telephone number(s) and address I have provided. This includes messages left with family members or other individuals that may answer my phone.

_____ initial 2. I hereby authorize Cicero Family Dentistry or a member of their staff to send out claims to my insurance company for services rendered to myself and/or my dependents and I agree to be responsible for all charges for dental services and materials not paid by the insurance company. The “Signature on File" will be valid as of the date signed below. I understand that dental insurance is a contract between myself and my insurance company. Cicero Family Dentistry files claims for me as a courtesy – they will not become involved in disputes between myself and the insurance company regarding deductibles, copayments, covered charges, “usual and customary” fees, etc., other than factual information as necessary.

_____ initial 3. I authorize the release of any information relating to the contents of my medical/dental records to physicians, dentists, or other medical specialists for the purposes of referral or consultation regarding a specific dental or medical condition.

_____ initial 4. I acknowledge that this office uses a collection agency in the event of failure of the patient to meet their financial obligations in the agreed upon time frame.

_____ initial 5. A copy of this office’s Notice of Privacy Practices has been made available to me.

IF APPLICABLE

_____ _____
Parent / Legal Guardian Name Relationship to Patient

As the parent or legal guardian, **I hereby authorize the following individuals listed below to bring my child / children to this office for dental care**:

_____

I authorize the dental staff to perform necessary dental services for my child including but not limited to x-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Parent / Legal Guardian Signature Date

Patient Signature _____ Date: _____

Cicero Family Dentistry

Insurance Information

Patient: _____ Date: _____

Insurance Plan 1:

Subscriber Information (policyholder – may be different than patient)**:**

Name: _____ Relationship to Patient: ☐ Self | ☐ Spouse | ☐ Child/Dependent

DOB: ___/___/___ SSN: _____ Phone: _____

Address: _____

Insurance Company Information:

Insurance Co.: _____ Phone: _____

Claims Address: _____

Insurance Plan Information:

Employer (if applicable): _____ Plan Name (if applicable): _____

Plan/Group # (if applicable): _____ ID (if not SSN): _____

Insurance Plan 2:

Subscriber Information (policyholder – may be different than patient)**:**

Name: _____ Relationship to Patient: ☐ Self | ☐ Spouse | ☐ Child/Dependent

DOB: ___/___/___ SSN: _____ Phone: _____

Address: _____

Insurance Company Information:

Insurance Co.: _____ Phone: _____

Claims Address: _____

Insurance Plan Information:

Employer (if applicable): _____ Plan Name (if applicable): _____

Plan/Group # (if applicable): _____ ID (if not SSN): _____

I hereby certify that, to the best of my knowledge, the provided information is true and accurate.

_____ _____

Signature Date

Records Request

Cicero Family Dentistry

Date: _____

Name of patient: _____ DOB: _____/_____/_____

Additional family members to be included:

Name: _____ DOB: _____/_____/_____

Name: _____ DOB: _____/_____/_____

Name: _____ DOB: _____/_____/_____

Name: _____ DOB: _____/_____/_____

I hereby authorize the release of dental records or knowledge concerning my dental health to Cicero Family Dentistry.

Signature _____ Date _____

(Patient or guardian)

Previous Dentist: _____

Phone: _____

Fax: _____

Email: _____

Please send x-rays by email if possible

Email: cicerofamilydentistry@gmail.com
Phone: 315-699-1919
Fax: 315-698-9608

Mailing address:
Cicero Family Dentistry
6221 State Route 31
Suite 102
Cicero, NY 13039

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