



## Dental Patient Information Form

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

If Child: Parent's Name: \_\_\_\_\_

Sex: M \_\_\_ F \_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

Home/Billing Address: \_\_\_\_\_

### **Insurance Information (Primary Coverage)**

Employer Name: \_\_\_\_\_ Employer Phone: ( ) \_\_\_\_\_

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employee SS#: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name of Insurance Co.: \_\_\_\_\_

Provider Mailing Address: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

### **Insurance Information (Secondary Coverage)**

Employer Name: \_\_\_\_\_ Employer Phone: ( ) \_\_\_\_\_

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employee SS#: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name of Insurance Co.: \_\_\_\_\_

Provider Mailing Address: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

**Please give all Insurance Cards to the Reception**



# Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

**(Check DK if you Don't Know the answer to the question)**

Do you wear contact lenses?  Yes  No  DK

Do you use controlled substances  Yes  No  DK

**Joint Replacement** - Have you had an orthopedic total joint (hip, knee, elbow, finger replacement)?  Yes  No  DK  
 Date: \_\_\_\_\_ If yes, have you had any complications?  Yes  No  DK  
 Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?  Yes  No  DK  
 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 metastatic cancer?  Yes  No  DK  
 Date Treatment began: \_\_\_\_\_

Do you use tobacco (smoking, snuff, chew, bidis)?  Yes  No  DK  
 If so, how interested are you in stopping? \_\_\_\_\_  
 (Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages?  Yes  No  DK  
 If yes, how much alcohol did you drink in the last 24 hours? \_\_\_\_\_  
 If yes, how much do you typically drink in a week? \_\_\_\_\_

**WOMEN ONLY** Are you:  
 Pregnant?  Yes  No  DK  
 Number of weeks: \_\_\_\_\_  
 Taking birth control pills or hormonal replacement?  Yes  No  DK  
 Nursing?  Yes  No  DK

**Allergies** - Are you allergic to or have you had a reaction to:  
 To all **yes** responses, specify type of reaction.

Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.**

Artificial (prothetic) heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify: _____			
Repaired (completely) in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____			
				Cancer/Chemotherapy/ Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurring infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infections: _____			
				Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Diabetes Type I or II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/ migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date: _____			
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? \_\_\_\_\_

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any disease, condition or problem not listed above that you think I should know about? \_\_\_\_\_

Please explain: \_\_\_\_\_

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# Health History Form

Email: \_\_\_\_\_

Today's Date: \_\_\_\_\_

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: \_\_\_\_\_ Home Phone: include area code \_\_\_\_\_ Business/Cell Phone: Include area code \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mailing Address

Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex:  M  F

SS # or Patient ID: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person?  
 Your Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Do you have any of the following diseases or problems:** (Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Active Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

## Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: _____			
Do you drink bottled or filtered water? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?: _____			
If yes, how often? <input type="checkbox"/> DAILY <input type="checkbox"/> WEEKLY <input type="checkbox"/> OCCASIONALLY				Date of last dental x-rays: _____			
Are you currently experiencing dental pain or discomfort? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today? _____							
How do you feel about your smile? _____							

## Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____ Phone: Include area code _____				If yes, what was the illness or problem? _____			
Address / City / State / Zip: _____							
Are you in good health? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking or have you recently taken any prescription or over the counter medicines? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any change in your general health within the past year? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____			
If yes, what condition is being treated? _____				_____			
				_____			
Date of last physical exam: _____							





Louis D. Rabice, D.D.S., P.C.

### **HIPAA Information and Consent Form**

The Health Insurance Portability and Accountability Act (HIPAA), provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Service. [www.hhs.gov](http://www.hhs.gov)

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for our care. Patient records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail or by any means convenient for the practice and /or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the patient and the practice.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, \_\_\_\_\_ hereby consent and acknowledge my agreement to the terms set forth above and any subsequent changes in office policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if necessary)

\_\_\_\_\_  
Date





Louis D. Rabice, D.D.S., P.C.

### FINANCIAL POLICY

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our **FINANCIAL POLICY**. If you have any questions, please ask the front desk.

**1. VERIFYING INSURANCE:** You are ultimately responsible to verify your dental coverage and for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance, are your financial responsibility.

**2. PAYMENT:** Payment is due **at the time of service**. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well. Once treatment is rendered, no refunds will be issued. If additional procedures are required during the course of treatment, the patient is responsible for the cost of additional treatment.

**3. INSURANCE INFORMATION:** New insurance as well as changes in insurance must be provided to this office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being **your** responsibility.

**4. CHANGES IN PERSONAL INFORMATION:** Changes in your address or telephone numbers should be kept current with our office. If this office is unable to contact you by telephone or mail and your balance is overdue, your account will be sent to a collection agency.

**5. REQUESTS FOR ADDITIONAL INFORMATION:** These must be responded to **immediately**. Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being **your** responsibility.

**6. PAYMENT PLANS:** Please see our staff at the front desk for details.

**7. BALANCES:** If your account balance exceeds 30 days, you will receive a notice informing you that your account is **overdue**. If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collections agency. If this happens, a **collection fee** (currently 39% of the balance) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus.

**8. RETURNED CHECKS:** There will be a **\$30** fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. Once a check has been returned, this office will no longer accept personal checks for payment.

**9. CANCELLATIONS/FAILED APPOINTMENTS:** We request **24-hours' notice** if you are cancelling an appointment. There will be a **\$50** fee for cancellations made without 24 hours' notice and for failed appointments ("no shows"). The \$50 will be posted to your account, and you will not be allowed to make any other appointments for yourself or your family members until it is **paid in full**.

\*\*\* Thank you for reading this information in full. Please sign below to acknowledge your understanding of the entire FINANCIAL POLICY. \*\*\*

**Patient/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient/Guardian Name (Please Print)** \_\_\_\_\_