JAG

JOHN A. GUERRIERI, DDS

WE'LL KEEP YOU SMILING

Date _____

Soc. Sec. # (optional) _____

Home Phone # (_____) _____

Cell # (_____) _____

Email Address _____

Patient Information (confidential)

How do you prefer to be contacted?
☐ Email ☐ Cell ☐ Home

Full Name _____ Birthdate _____

Preferred Name to be Called _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Patient's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You to Us? _____

Emergency Contact Name _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Home Phone # _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone # (_____) _____ SS # _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Dental Insurance Information

Subscriber _____ Relationship to Subscriber _____

Subscriber Birthdate _____ Subscriber Social Security # _____

Subscriber Employer _____ Union or Local # _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Provider _____ Group # _____ Policy ID # _____

Insurance Provider Address _____ City _____ State _____ Zip _____

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

Subscriber _____ Relationship to Subscriber _____

Subscriber Birthdate _____ Subscriber Social Security # _____

Subscriber Employer _____ Union or Local # _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Provider _____ Group # _____ Policy ID # _____

Insurance Provider Address _____ City _____ State _____ Zip _____

Over Please

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name_____ Office Phone #_____ Date of Last Exam _____

Are you under a physician's care now? ◯ Yes ◯ No If yes _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? ◯ Yes ◯ No If yes _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you use controlled substances? ◯ Yes ◯ No If yes _____

Other? ◯ Yes ◯ No If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes _____

Name of previous dentist and location_____ Date of last exam _____

	Yes	No
Do your gums bleed while brushing or flossing?	◯	◯
Are your teeth sensitive to anything hot or cold?	◯	◯
Are your teeth sensitive to anything sweet/sour?	◯	◯
Do you have any teeth pain?	◯	◯
Do you have any sores/lumps in or near mouth?	◯	◯
Do you have frequent headaches?	◯	◯
Have you had any orthodontic treatment?	◯	◯
Do you like your smile?	◯	◯

	Yes	No
Have you ever experienced any of the following jaw problems?	◯	◯
Clicking	◯	◯
Pain (joint, ear, side of face)	◯	◯
Difficulty opening or closing	◯	◯
Difficulty chewing	◯	◯
Do you clench or grind your teeth?	◯	◯
Do you wear dentures or partials?	◯	◯

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform the dental office of any changes in my medical status. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dental or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If my account becomes delinquent and is sent to collections, I will be responsible for all services, collections and attorney fees.

Signature of Patient (or Parent/Legal Guardian if a minor)_____ Date: _____

Notice of Privacy Practice Acknowledgement

John A. Guerrieri, DDS, PLLC
2100 Walworth-Penfield Road
Walworth, NY 14568

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing more complete description of the use and disclosure of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restriction.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

(Office Use Only)

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

JOHN A. GUERRIERI, DDS
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FINANCIAL and CANCELLATION POLICIES

Financial Policy

All Payments / Co-Payments are due the day service is provided. Our office accepts cash, personal checks, Discover, Visa, Mastercard as well as Flexible spending and beneversal cards. For charges of $500 or greater, a 5% courtesy will be extended for full cash or check payment **in ADVANCE** of treatment date. Outside financing with 0% interest is available upon request and approval. If you would like more information regarding these financing plans please ask.

Your insurance is a contract between you and your insurance company. As a courtesy we will provide you with an estimate of coverage and will submit all insurance claims to your insurance provider for you. All charges you incur are your responsibility regardless of insurance coverage. If payment is not received after 60 days or if insurance claim is denied by your insurance company, you will be responsible for paying the full amount.

Should the fees for professional services not be paid in accordance with the provisions herein finance charges can and will be applied to all past due amounts. If the account is in default and turned over to collection, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due.

Returned checks will be subject to a $25 bank fee. We retain the right to refuse checks as payment.

Cancellation Policy

As a courtesy to other patients our office must be given **at least a 24 hour notice** if you need to cancel or reschedule any appointment. If a 24 hour notice is not given you will be charged $50 for every hour that was scheduled. We may also request full payment prior to reserving future time in our schedule. Our office holds the right to remove any appointment from our schedule.

Authorization and Release

I certify that I have read, understand and agree to the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records of any treatment or examine rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If your account becomes delinquent and is sent to collection you will be responsible for all service, collections and attorney fees.

_____	_____	_____
Patients Signature	Date	Signature & Date of Guarantor, if a Minor
_____		_____
Print Patients Name		Print Name of Guarantor, if a Minor