Welcome To Our Office!

Our team looks forward to bringing you into our family of patients.
Please help us meet all your dental needs by completing this form (both pages).
If you have any questions or need assistance, please ask us - we will be happy to help.

Please complete the following confidential information...

Date	Salutation ☐ Mr. ☐ Mrs. ☐ Ms.	Patient Name	Date of Birth	SSN
Spouse/Parent Name		Address		
City	State	Zip	Email Address	
Home Phone	Business Phone	Cell Phone		

Getting to know you...

Is another member of your family or relative a patient at our office?

Name	Relationship	Referred to us by
Person to contact for emergency	Phone number	

Note: For your protection, please present your drivers license for us to photocopy and keep within your file.

Consent for Treatment...

1.) I hereby authorize Dr. Pieczynski or designated staff to take x-rays, study model photographs, and any other diagnostic aids deemed appropriate by Dr. Pieczynski to make a thorough diagnosis of (name of patient) _____'s dental needs.

2.) Upon such diagnosis, I authorize Dr. Pieczynski to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3.) I agree to the use of anesthetics, sedatives and other medication as necessary. I understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

_____ _____
Patient Date

_____
Parent or Responsible Party

Patient Name

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

If yes, for what?

Physician's Name	Phone	Address
City	State	Zip

Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No

Are you taking any medication, drugs or pills now? ☐ Yes ☐ No

If yes, please list

Are you aware of having an allergic (or adverse reaction) to any medication or substance? ☐ Yes ☐ No

If yes, please list

Do you need to be premedicated for dental procedures? ☐ Yes ☐ No

If yes, what is the name of your physician?	Phone	Also, what medication has been prescribed?

Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No

Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item.

	Yes	No		Yes	No		Yes	No
Heart (Surgery, Disease, Attack)	☐	☐	Ulcers	☐	☐	Hepatitis A (infectious) B (serum)	☐	☐
Chest Pain	☐	☐	Diabetes	☐	☐	Venereal Disease	☐	☐
Congenital Heart Disease	☐	☐	Thyroid Problems	☐	☐	A.I.D.S	☐	☐
Heart Murmur	☐	☐	Glaucoma	☐	☐	H.I.V. Positive	☐	☐
High Blood Pressure	☐	☐	Contact Lenses	☐	☐	Cold Sores/Fever Blisters	☐	☐
Mitral Valve Prolapse	☐	☐	Emphysema	☐	☐	Blood Transfusion	☐	☐
Artificial Heart Valve	☐	☐	Chronic Cough	☐	☐	Hemophilia	☐	☐
Heart Pacemaker	☐	☐	Tuberculosis	☐	☐	Sickle Cell Disease	☐	☐
Rheumatic Fever	☐	☐	Asthma	☐	☐	Bruise Easily	☐	☐
Arthritis/Rheumatism	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐
Cortisone Medicine	☐	☐	Latex Sensitivity	☐	☐	Yellow Jaundice	☐	☐
Swollen Ankles	☐	☐	Allergies or Hives	☐	☐	Neurological Disorders	☐	☐
Stroke	☐	☐	Sinus Trouble	☐	☐	Epilepsy or Seizures	☐	☐
Diet (Special/Restricted)	☐	☐	Radiation Therapy	☐	☐	Fainting or Dizzy Spells	☐	☐
Artificial Joints (hip, knee, etc.)	☐	☐	Chemotherapy	☐	☐	Nervous/Anxious	☐	☐
Kidney Trouble	☐	☐	Tumors	☐	☐	Psychiatric/Psychological Care	☐	☐

Do you use more than two pillows to sleep? ☐ ☐

Have you lost or gained more than 10 pounds in the past year? ☐ ☐

Do you have or have you had any disease, condition, or problem not listed? ☐ ☐

If yes, please list:

Women. Are you: Pregnant? ☐ Yes ☐ No Months____ Nursing ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

Financial Information

Thank you for choosing Denise M. Pieczynski, D.M.D., P.A. We are committed to providing you a comfortable, relaxed experience, as well as the best oral health care provided anywhere. **Your clear understanding of our financial policy is important to our professional relationship, so we ask that you read, initial as indicated, and sign**.

Payment is due at the time of service. If your treatment requires special payment arrangements, our financial coordinator will be happy to work this out with you prior to beginning your treatment. We accept: **Cash, Check, MasterCard, Visa, Discover, American Express, Debit Cards, and CareCredit.**

Person Financially Responsible for the Account:

Name:_____ Relationship to Patient:_____

Address:_____

Phones: H/_____W/_____C/_____

Date of Birth:_____ Social Security #: _____

Returned Checks:
There will be a $25.00 charge for all bank returned checks. If a second check is presented and returned, we will require future payments to be made by cash or credit card. **Initial:___**

Insurance Coverage:
Do you have dental insurance? YES:_____ NO:_____

We will file your insurance as a courtesy to you; however, we do not take it as a form of payment. **Payment is due at the time of service.** If you have insurance, please provide us with your card, as well as your driver's license or other form of identification with a photo ID. To assure your information is always current and accurate, please report any changes in personal information or insurance changes. **Initial:_____**

We make no claim to know what services your insurance plan covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility to know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions regarding covered services. In addition, be aware that some of the services may not be covered services by your insurance. All charges are your responsibility. **Initial:_____**

Insurance Claims Processing:
The office will supply factual information to facilitate claim processing. Your insurance policy is a contract between you and your insurance company. **Initial:_____**

Out of Network and PPO Plans:
We are considered out of network for all plans. We are happy to bill your insurance company as a courtesy to you, but payment is due at the time of service. **Initial:_____**

Patient Release for Records:
I hereby authorize the office of Denise M. Pieczynski, D.M.D., P.A., to release to my insurance company any necessary information needed to file and expedite payment on my claim. **Initial:_____**

Patient Payment:
I have read, understand, and abide to the terms stipulated above. I have requested clarification of any parts or parts of this financial agreement that I do not understand. I agree to be fully responsible for total payment of procedures performed in this office. I agree that should this account be referred to an attorney or agency for collection, I will be responsible for all collection costs, attorney fees, and court costs. I, the undersigned, have read the above and assume the responsibility for my account. **Initial:_____**

Patient Name: _____ Date: _____

_____
Signature of Person Financially Responsible for this Account

CONSENT FOR RELEASE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. These rights have been outlined in our office's Notice of Privacy Practices (NOPP), which is located in our reception area for easy patient review.

I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release the Practice, its employees and agents for any and all disclosures as stated in the NOPP.

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

I hereby authorize Dr. Denise Pieczynski to use and disclose any necessary information from my dental record, verbally, faxed, text messages, emailed or by mail, in accordance with our Notice of Privacy Practices.

PRINT FULL NAME

DATE

SIGNATURE