Welcome to Our Office

PATIENT

Date_____

Name:_____
Birthday___/___/____ Age____ SS#_____
__Single __Married __Divorced __Widowed __ Separated
Employer:_____
Employer Address:_____
_____
Occupation:_____
My Dentist is:_____

Home Address:_____
_____
Home Phone_____
Work Phone_____
Cell Phone_____
E-mail Address_____
When and where is the best time to reach you_____
Who may we thank for referring you? _____
Other family members seen by us:_____
My medical doctor is:_____

GUARANTOR

Same as Above?_____
Person Responsible for account if other than Patient
_____
Address (Same as above? _____Y ____N)
_____
_____

Home Phone_____
Work Phone_____
Cell Phone_____
Relationship_____
SS#_____
Employer_____

DENTAL INSURANCE

PRIMARY

Insurance Period Name_____
Insurance Period Phone#_____
Group # (Plan, Local or Policy#)_____
Insured's Birthdate____/____/_____ Relationship_____
Insured's ID or SS#_____
Insured's Employer_____

SECONDARY

Insurance Period Name_____
Insurance Period Phone#_____
Group # (Plan, Local or Policy#)_____
Insured's Birthdate____/____/_____ Relationship_____
Insured's ID or SS#_____
Insured's Employer_____

MEDICAL INSURANCE (SOME PROCEDURES MAY BE COVERED UNDER MEDICAL)

PRIMARY

Insurance Period Name_____
Insurance Period Phone_____
Group # (Plan, Local or Policy#)_____
Insured's Name_____

SECONDARY

Insurance Period Name_____
Insurance Period Phone_____
Group # (Plan, Local or Policy#)_____
Insured's Name_____

FINANCIAL POLICY

Payment is expected at the time services are rendered, unless other arrangement have been made in advance.

Please understand that insurance benefits are determined between you, your employer and your insurance company. You are ultimately responsible for our fees which are within the usual and customary guidelines. For patients with verified insurance plans, deductibles and copayments are due at the time of treatment.

Past due account will be subject to additional collection costs, legal costs and A $1^{1/2}$ % monthly interest charge.

AUTHORIZATION AND RELEASE

I authorize the doctor to release any information including the diagnosis and records of any treatments or examination rendered to me or my child to third party payors and/or health practioners in accordance with the federal privacy Act. I authorize and request my insurance carriers to pay insurance benefits otherwise payable to me, to the treating doctor. I understand that my insurance carriers 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

_____

Signature of Patient (Or Parent/Guardian if minor) **Date**

MEDICAL HISTORY

Your Current Health is: ___Good ___Fair ____Poor
Are you Currently under the care of a Physician? ___Yes __No
Please Explain:_____
_____
_____
_____
_____
_____
Do you smoke? Y or N If Yes: How much? _____ How Long?_____
Are you taking any medications or drugs? ____Yes ____No
If so, Please List:_____
_____
_____
_____
_____
_____
Pharmacy Phone Number:_____

Are you taking any of the following Medications?
Coumadin/Warfarin_____ Risdronate (Actonel)_____
Etidronate (Didronel)_____ Zoledronate (Zometa) _____
Pamidronate (Aredia) _____ Ibandronate (Boniva) _____
Alendronate (Fosamax) _____ **NONE OF THE ABOVE _____**
Please check if you are allergic to any of the following Medications
Aspirin _____ Tetracycline _____
Codeine _____ Latex _____
Narcotics _____ Other _____
Local Anesthetics _____
Penicillin _____
Amoxicillin _____
Erythromycin_____ no drug allergies–check here____
WOMEN OF CHILDBEARING YERARS:
Do you take birth control pills? ____Yes ____No
Are you pregnant? ___Yes ___No
Are you nursing? ____Yes ____NO

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

Hospitalization_____ Heart Surgery_____
Chest Pain / Angina_____ Pacemaker_____
Shortness of Breath_____ High Blood Pressuer_____
Heart Valve Replacement_____ Asthma_____
Heart Murmur/Heart Valve Disease_____ Emphysema_____
Mitral Valve Prolapse_____ Difficulty Breathing_____
Rheumatic Heart Disease_____ Tuberculosis_____
Heart Attack_____ Hepatitis_____
Congenital Heart Defect_____ Liver Disease_____
HIV+ / AIDS_____ Psychiatric Problems_____
Blood Transfusion_____ Epilepsy / seizures_____
Hemophilia / Abnormal Bleeding___ Stroke_____
Cancer_____ Headaches_____+_____
Chemotherapy_____ Sinus Problems_____
Radiation Therapy_____ Artificial Joint Replacement_____
Diabetes_____ Tempormandibular Joint Disease(TMJ)_____
Kidney Problems_____ **NONT OF THE ABOVE_____**
Drug / Alcohol Abuse_____

INFORMED CONSENT FOR SURGERY

I hearby Authorize Dr. Carotenuto and staff to perform the following procedures_____
_____
_____
And to administer the anesthetic I have chosen which is ( ) Local ( ) Intravenous sedation ( ) general anesthesia.
Other Treatment options are:_____
_____

1. Certain Complications may occur as a result of my surgery which include but are not limited to: Swelling Bruising, Stiffness of the jaw muscles and jaw joint, Unexpected drug reactions including allergic reactions.
2. With tooth extraction, I understand that there may be unexpected damage to adjacent teeth or fillings, sharp ridges or bone splinters that may require later surgery to correct, "Dry socket" conditions which may require additional care or small fragments of tooth root which may be left in place to avoid damage to vital structures such as nerves or the sinus.
3. Lower tooth roots may be very close to the nerve and surgery may result in a numb feeling of the lip, chin, gums or tongue which may last for weeks, months or rarely may be permanent. On upper teeth whose roots are close The sinus, sinus infection may develop. A root may enter the sinus, And/or an opening from the mouth to the sinus may occur which may require surgery to close immediately or at a later date.
4. Anesthetic ricks include sorenes, bruising, infection, prolonged numbness and very rare allergic reactions, extremely rare reactions have been reported, these include heart attack, stroke, or even death. When medications are placed into a vein there may be inflammation at the site of injection (phlebitis), which may cause prolonged discomfort and/or disability, and may require additional care.
5. If I am to have general anesthesia, I understand that I am to have had nothing to eat or drink for six hours prior to surgery. To do otherwise could be life threatening.
6. I also understand that a responsible adult must accompany me to my appointment to drive me home after general anesthesia.
7. I understand that no guaranteed results have been offered or promised, and I give my free and voluntary consent for treatment I realize that my doctor may discover conditions that may alter the planned surgery and I give my permission for those procedures deemed advisable in his professional opinion to complete my surgery.
8. I understand that I have an opportunity to have my questions answered before surgery.

_____
Patient's Guardian's Signature Date

_____
Witness's Signature Date

_____
Doctor's Signature Date

QUESTIONAIRE

I am interested in:

Replacing Missing teeth with dental implants_____
Preserving bone in extraction sites so that I can have implants in the future_____
Cosmetic Removal of facial growths of marks_____
"Botox" Injections for wrinkles_____
Injection of wrinkle lines with cosmetic dermal fillers like "Restylane"_____
Facial Peels or laser skin resurfacing_____