

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Male Female Married Single Child Other _____ Email: _____
Social Security #: _____ Birth Date: _____ DL# _____
Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
Address: _____
Street Apartment #
City State Zip Code
Employer Name: _____ Employer #: _____

Health History

Name of Physician: _____ Phone: _____ Date last seen: _____
Are you now under the care of a physician? Yes No
Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
Please list any medications you are currently taking: _____
Please list any medications you are allergic to: _____

Have you ever had any of the following? Please check those that apply:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Penicillin Allergy	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Tumors
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Jaundice	Due date: _____	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Arthritis Joints	<input type="checkbox"/> Fainting	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Radiation Treatment	OTHER: _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> _____
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Metal or Latex Allergy	<input type="checkbox"/> Sinus Problems	
<input type="checkbox"/> Codeine Allergy	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other Allergies: _____	<input type="checkbox"/> Stomach Problems	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur		<input type="checkbox"/> Stroke	

- Do you smoke or chew tobacco? Yes No
- Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? Yes No
- Do you have any health problems that need further clarification? Yes No

Dental History

Date of Last Dental Visit: _____ Reason for this visit: New Patient Exam ER Consultation Other: _____
• Do you brush and floss on a daily basis? Yes No
• Have you ever had any complications following dental treatment? Yes No
• Are you having pain or discomfort at this time? Yes No
• Are you nervous or apprehensive about your dental treatment? Yes No
• Are you unhappy with the appearance of your teeth? Yes No
• Have you ever had an unusual reaction to dental anesthetic? Yes No
Do you have or have you ever had any of the following? Please check those that apply:
 Bleeding or sore gums Food trapped between teeth Periodontal (gum) Treatment Clinching or grinding teeth
 Loose/shifting teeth Complications from extractions Orthodontic Treatment (Braces) Pain/clicking/popping of jaw
 Sensitivity to hot/cold/sweets

Health Questionnaire Acknowledgment and Consent to Proceed

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment. I authorize Dr. Anabel Curiel Franciskato and/or such associates or assistants designated to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval. I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including filings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Email: _____ DL# _____ Best time to call: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____
Name and number of someone not living with you: _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____
Address: _____
Street _____ City, State Zip Code _____ Phone _____

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID # _____ Group # _____
Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____
Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name, Address and Phone: _____

Secondary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID # _____ Group # _____
Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____
Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name, Address and Phone: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for by cash or credit card at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Any and all benefits from insurance companies and other third party payors that are payable to Patient or on behalf of Patient for dental care services and related payments for services rendered or provided to Patient are hereby transferred and assigned to Dr. Franciskato for the exclusive purpose of paying for charges associated with dental care services provided to Patient in this office. It is understood and intended that all insurance companies and other third party payors will pay benefits directly to Dr. Franciskato in payment of Dr. Franciskato's charges and the charges of any other health care providers for whom Dr. Franciskato is authorized to bill in connection with health care services provided to Patient.

Patient agrees to be financially responsible for failed, cancelled, or rescheduled appointment fees. These fees range in price from \$25 up to, but not in excess of, \$125 depending on the nature of treatment for which you were appointed. These fees are not billable to insurance and are thus payable directly by patient. Our office requires a minimum of 48 hours notice prior to a scheduled appointment to exempt you from the failed appointment fees.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within ten (10) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. An additional 33% will be added to my account if turned over to a collection agency.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____