IN CASE OF AN EMERGENCY WHILE I AM IN THE OFFICE PLEASE CALL:

NAME: _____

RELATIONSHIP: _____

HOME PHONE: _____ WORK: _____

NAME: _____

RELATIONSHIP: _____

HOME PHONE: _____ WORK: _____

OTHER THAN YOURSELF, WHO ELSE MAY PICK UP PAPERS, X-RAYS, OR ASK QUESTIONS ABOUT THIS PATIENT

NAME: _____

RELATIONSHIP: _____

HOME PHONE: _____ WORK: _____

NAME: _____

RELATIONSHIP: _____

HOME PHONE: _____ WORK: _____

SIGNATURE **DATE**

(RESPONSIBLE PARTY, PARENT OR GUARDIAN IF PATIENT IS UNDER 18)

ROSSETTI DENTAL ASSOCIATION, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

PATIENT INFORMATION

Patient's Name:_____ Today's Date:_____/_____/_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Mobile Phone: (_____) _____-_____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

DOB:_____/_____/_____ Social Security #:_____-_____-_____ Marital Status: _____

Medical Alerts:

PRIMARY DENTAL INSURANCE INFORMATION

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SS #: _____-_____-_____ DOB:_____/_____/_____ EMPLOYER: _____

GROUP #: _____ INSURANCE COMPANY: _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SS #: _____-_____-_____ DOB:_____/_____/_____ EMPLOYER: _____

GROUP #: _____ INSURANCE COMPANY: _____

I authorize the dentist to release any information including the diagnosis and the 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 or dental group insurance benefits otherwise payable to me to be paid directly to the dentist. I also understand the price quoted to me is just an estimate of my charges due. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If my account should be placed for collection I also understand that I am responsible for all collection fees, attorney fees, and court cost.

PERSON FILLING OUT PAPERS FOR THE PATIENT

NAME: _____ RELATION TO PATIENT: _____

SS #_____/_____/_____DOB:_____/_____/_____TYPE OF PICTURE ID: _____

ADDRESS: _____

EMPLOYER: _____ WORK PHONE: _____

SIGNATURE _____ DATE _____

(RESPONSIBLE PARTY, PARENT OR GUARDIAN IF PATIENT IS UNDER 18)

PATIENT MEDICAL INFORMATION

Physician Name: _____ Physician Phone: (_____) _____-_____

Pharmacy: _____ Pharmacy Phone: (_____) _____-_____

Do you smoke or use tobacco? Y/ N Height: _____ Weight: _____ Sex: M / F

Conditions	Y	N	Conditions	Y	N	Conditions	Y	N	Allergies	Y	N
Artificial Bones			Artificial Heart Valve			Hemophilia			Aspirin		
Epilepsy			Mitral Valve Prolapse			Hepatitis A			Codeine		
Colitis			Difficulty Breathing			Hepatitis B			Dental		
Heart Attack			Abnormal Bleeding			Seizures			Anesthetics		
Heart Surgery			Taking Blood Thinner			Shingles			Erythromycin		
Diabetes			Hip or Knee Replacement			Sinus Problems			Jewelry		
Glaucoma			Congenital Heart Defect			Stroke			Latex		
Pace Maker			Blood Transfusion			Thyroid Problems			Metals		
Emphysema			Fainting Spells			Cancer			Penicillin		
Stents			Fever Blisters			Sickle Cell Disease			Tetracycline		
Hay Fever			Rheumatic Fever			Cholesterol			Sulfa		
Shunts			Frequent Headaches			Tuberculosis			**List Other**		
HIV + AIDS			High Blood Pressure			Ulcers			**Allergies Below**		
Alcohol Abuse			Kidney Disease			Liver Disease					
Anemia			Psychiatric Problems								
Angina Pectoris			Low Blood Pressure								
Arthritis			Pain in Jaw Joints								
Asthma			Venereal Disease								

If Female Please answer the following:

1) Are you taking Birth Control Pills? Yes / No

2) Are you Pregnant? Yes / No If Yes # of week's _____ 3) Are you Nursing? Yes / No

List Medications

Y N Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes please describe below.

SIGNATURE **DATE**

(RESPONSIBLE PARTY, PARENT OR GUARDIAN IF PATIENT IS UNDER 18)