MASCI & HALE

Advanced Aesthetic & Restorative Dentistry
2134 State Rt 208, Montgomery, NY 12549

Patient Information

Patient Name: _____
Last First

Date of Birth: _____ Gender: _____ SS#: _____

Address: _____
Street Apt #

_____
City State Zip

Contact #'s: Home _____ Work _____

Cell _____ Email _____

Financial Information

Insurance Plan: _____
Please have your Insurance Benefits Card available for verification

Employer: _____

Plan Holder (if other than self) _____

Date of Birth: _____ SS/ID #: _____
Relationship to patient: _____
If Spouse- Present status: Married Separated Divorced

Aesthetics

YES NO Are you happy with the appearance of your teeth?
YES NO Would you like your teeth to look whiter?
YES NO Would you like to see your smile look different?
YES NO Do you like the shape of your teeth?
YES NO Are you happy with the appearance of your lips?
YES NO Do you have discolored teeth that bother you?
YES NO Are you here for a specific reason?
Please Explain: _____

_____

Which of the following would keep you for pursuing your dental treatment?
___ Cost ___ Fear ___ Lack of Time ___ Lack of Importance

Diagnostic materials may include intra-oral pictures, radiographs, digital radiographs, study models, & photographs. This material may be used for lectures, articles, marketing materials and/or publications. I understand the dental treatment presented to me is my financial responsibility. I further understand that all fees are due and payable up front, at the time services are rendered unless other arrangements have been made.

Signature: _____ **Date:** _____

Medical Information: side 1

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Patient Info

Patient Name _____
Last First MI (Preferred Name)

SS #: _____

Medical Info

Yes No 1) Are you in good health?
Yes No 2) Has there been any change in your general health within the past year?
Yes No 3) Are you now under the care of a physician?
If so, what is the condition being treated? _____
Physician's Name _____
Address _____ City _____
State _____ Zip _____ Phone _____
Yes No 4) Date of last physical examination _____
Yes No 5) Are you taking medicines, including non-prescription medicine?
If yes, what medicine? _____
_____

Women Only

Yes No 6) Are you pregnant?
Yes No 7) Nursing?
Yes No 8) Taking birth control pills?

Conditions

Do you have any of the following diseases or problems?

Yes No 9) Abnormal bleeding
Yes No 10) AIDS or HIV
Yes No 11) Anemia
Yes No 12) Arthritis
Yes No 13) Rheumatoid arthritis
Yes No 14) Asthma
Yes No 15) Blood transfusion If yes, date _____
Yes No 16) Cancer/chemotherapy/radiation treatment
Yes No 17) Cardiovascular disease
Yes No 18) Angina
Yes No 19) Arteriosclerosis
Yes No 20) Artificial heart valves
Yes No 21) Coronary insufficiency
Yes No 22) Coronary occlusion
Yes No 23) Damaged heart valves
Yes No 24) Heart attack
Yes No 25) High blood pressure
Yes No 26) Inborn heart defects
Yes No 27) Mitral valve prolapse
Yes No 28) Pacemaker
Yes No 29) Chest pain upon exertion
Yes No 30) Chronic pain
Yes No 31) Persistent diarrhea
Yes No 32) Disease, drug or radiation-infection induced immunosurpression
Yes No 33) Diabetes, if yes, specify ❑ Type I ❑ Type II
Yes No 34) Dry mouth
Yes No 35) Eating disorder Specify _____
Yes No 36) Epilepsy
Yes No 37) Fainting spells or seizures
Yes No 38) G.F. reflux
Yes No 39) Glaucoma
Yes No 40) Hemophilia
Yes No 41) Hepatitis, jaundice or liver disease
Yes No 42) Recurrent infections Specify _____
Yes No 43) Kidney problems
Yes No 44) Low blood pressure
Yes No 45) Mental health disorders Specify _____
Yes No 46) Migraines
Yes No 47) Night sweats
Yes No 48) Neurological disorders Specify: _____
Yes No 49) Osteoporosis
Yes No 50) Persistent swollen glands in neck
Yes No 51) Respiratory problems
If yes, specify: ❑ Emphysema ❑ Bronchitis
Yes No 52) Severe headaches
Yes No 53) Severe or rapid weight loss
Yes No 54) Sexually transmitted disease
Yes No 55) Sinus trouble
Yes No 56) Sleep disorder
Yes No 57) Sores or ulcers in the mouth
Yes No 58) Stroke
Yes No 59) Systemic lupus erythematosus
Yes No 60) Thyroid problems
Yes No 61) Tuberculosis
Yes No 62) Ulcers
Yes No 63) Excessive urination
Yes No 64) Any other diseases,condition or problem not listed above? Please explain:
_____

continues on other side

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Medical Information: side 2

Conditions

65) Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
If so, what antibiotic and dose? _____
Name of physician or dentist: _____ Phone: _____

66) Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
If so, when was this operation done? _____

67) If yes, Have you had any complications or difficulties with your prosthetic joint? _____
_____

Allergies

Are you allergic or have you had a reaction to:

Yes No 68) Local anesthetics
Yes No 69) Aspirin
Yes No 70) Penicillin or other antibiotics
Yes No 71) Barbiturates, sedatives or sleeping pills
Yes No 72) Sulfa drugs
Yes No 73) Codeine or other narcotics

Yes No 74) Latex
Yes No 75) Iodine
Yes No 76) Hay fever/seasonal
Yes No 77) Animals
Yes No 78) Food (specify) ____
Yes No 79) Other (specify) ____

If yes responses, specify type or reaction _____

Signatures

I understand and authorize Drs. Masci and Hale and associates to perform and/or administer any and all forms of treatment, medication and anesthesia that may be necessary. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I certify that I have read and understand the above.

Print Name: _____

Signature: _____ Date: _____

PATIENT HIPAA AWARENESS

With my permission, Drs. Masci & Hale may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Drs. Masci & Hale's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Drs. Masci & Hale reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Drs. Masci & Hale may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Drs. Masci & Hale may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and/or Confidential."

With my permission, the office of Drs. Masci & Hale may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Drs. Masci & Hale restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Drs. Masci & Hale to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____
Signature of Patient or Legal Guardian

_____
Date

_____
Patient's Name

_____
Print Name of Patient or Legal Guardian

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(845)457-5763
www.aReasonToSmile.com

Financial Responsibility Awareness

Masci & Hale Advanced Aesthetic and Restorative Dentistry is a Fee for Service, Out of Network (non-insurance participating) Practice. This means that we are not contracted with any dental insurance companies and do not accept insurance payments as *full coverage* for procedures. We will do all the necessary paperwork & claim submissions for you.

As a courtesy to our patients with insurance plans that are willing to send our office their payment directly, we will accept that insurance check as the initial payment and then bill our patient for any remaining balance. If they cover our fee in full, you will not be billed for any balance.

A credit card can be left on file ahead of time for automatic payment of any out of pocket balances.

There are some insurance companies that will not send us their payment directly. They will however reimburse the patient if it's a PPO policy. For patients with these plans, you will be responsible for full fees at time of service unless other payment arrangements have been agreed upon.

By signing below, you agree that you fully understand our office financial policy and are aware that you will be responsible for any/all fees remaining after your insurance has paid their allowable portion.

Name: _____ **Date:** _____