WELCOME

PATIENT INFORMATION

Date _____ ID#/SS# _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐M ☐F Age_____ Birthdate _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Occupation _____

Employer _____

Employer Address _____

Employer Phone (_____)_____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

DENTAL INSURANCE

Who is responsible for this account?_____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name _____

Birthdate _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

PHONE NUMBERS

Home (_____)_____ Work (_____)_____ Ext _____ Spouse's Work (_____)_____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship_____

Home Phone (_____)_____ Work Phone (_____)_____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate If you have had any of the following:

Bad Breath	☐Yes	☐No
Bleeding gums	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No
Chew on one side of mouth	☐Yes	☐No
Cigarette, pipe, or cigar smoking	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No
Dry mouth	☐Yes	☐No
Fingernail biting	☐Yes	☐No
Food collection between the teeth	☐Yes	☐No
Foreign objects	☐Yes	☐No
Grinding teeth	☐Yes	☐No
Gums sswollen or tender	☐Yes	☐No
Jaw pain or tiredness	☐Yes	☐No
Lip or cheek biting	☐Yes	☐No
Loose teeth or broken fillings	☐Yes	☐No
Mouth Breathing	☐Yes	☐No
Mouth pain, brushing	☐Yes	☐No
Orthodontic treatment	☐Yes	☐No
Pain around ear	☐Yes	☐No
Peridontal treatment	☐Yes	☐No
Sensitivity to cold	☐Yes	☐No
Sensitivity to heat	☐Yes	☐No
Sensitivity to sweets	☐Yes	☐No
Sensitivity when biting	☐Yes	☐No
Sores or growths in your mouth	☐Yes	☐No

How often do you floss? _____

How often do you brush?_____

Patient Name _____

Date of last dental visit_____

Have you ever taken a group of drugs called **Bisphosphonates** which are taken to increase bone density? (**Fosamax, Boniva, Actonel etc**) Bisphosphonates taken while undergoing Periodontal surgery/ Tooth extraction/Oral surgery increase the chance of Osteonecrosis of the jaw. YES NO

AIDS/HIV	YES NO	JAUNDICE	YES NO
ANEMIA	YES NO	JAW PAIN	YES NO
ARTHRITIS/RHEUMATISM	YES NO	KIDNEY DISEASE	YES NO
ARTIFICIAL HEART VALVES	YES NO	LIVER DISEASE	YES NO
ARTIFICIAL JOINTS	YES NO	LOW BLOOD PRESSURE	YES NO
ASTHMA	YES NO	MITRAL VALVE PROLAPSE	YES NO
BACK PROBLEMS	YES NO	NERVOUS PROBLEMS	YES NO
BLEEDING ABNORMALLY,WITH	YES NO	PACEMAKER	YES NO
EXTRACTIONS OR SURGERY	YES NO	PSYCHIATRIC CARE	YES NO
BLOOD DISEASE	YES NO	RADIATION TREATMENT	YES NO
CANCER	YES NO	RESPIRATORY DISEASE	YES NO
CHEMICAL DEPENDENCY	YES NO	RHEUMATIC FEVER	YES NO
CHEMOTHERAPY	YES NO	SCARLET FEVER	YES NO
CIRCULATORY PROBLEMS	YES NO	SHORTNESS OF BREATH	YES NO
CONGENITAL HEART LESIONS	YES NO	SINUS TROUBLE	YES NO
CORTISONE TREATMENTS	YES NO	SKIN RASH	YES NO
COUGH,PERSISTENT OR BLOODY	YES NO	SPECIAL DIET	YES NO
DIABETES	YES NO	STROKE	YES NO
EMPHYSEMA	YES NO	SWOLLEN FEET OR ANKLES	YES NO
EPILEPSY	YES NO	SWOLLEN NECK GLANDS	YES NO
FAINTING OR DIZZINESS	YES NO	THYROID PROBLEMS	YES NO
GLAUCOMA	YES NO	TONSILLITIS	YES NO
HEADACHE	YES NO	TUBERCULOSIS	YES NO
HEART MURMUR	YES NO	TUMOR OR GROWTH ON	YES NO
HEART PROBLEMS	YES NO	HEAD OR NECK	
HEPATITIS TYPE____	YES NO	ULCER	YES NO
HERPES	YES NO	VENEREAL DISEASE	YES NO
HIGH BLOOD PRESSURE	YES NO	WEIGHT LOSS, UNEXPLAINED	YES NO
DO YOU WEAR CONTACT LENSES	YES NO	IMPLANTS TYPE_____	YES NO
WOMEN:			
ARE YOU PREGNANT? DUE DATE_____	YES NO	ARE YOU NURSING?	YES NO
TAKING BIRTH CONTROL PILLS?	YES NO		

DOCTORS SIGNATURE_____

MEDICATIONS

List any medications you are taking and the correlating diagnosis:

_____

_____

_____

_____

_____

_____

pharmacy name_____

phone#( )_____

ALLERGIES?

ASPIRIN	LOCAL ANESTHETIC
BARBITURATES	PENICILLIN
CODEINE	SULFA
IODINE	OTHER?
LATEX	

PATIENT SIGNATURE_____

The Practice of Dentistry involves treating the whole person. If the dentist determines that there may be a potentially Medically-compromised situation, Medical consultation may be needed prior to commencement of the dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature_____
Date_____

Physician's Name_____
Phone Number_____

I certify that I have read and understand these forms. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications. Further, I will not hold my dentist, or any member of his/her staff, responsible for any errors of omissions that I may have made in the completion of these forms.

Signature of Patient (Parent or Guardian)_____
Date_____

Signature of Dentist_____
Date_____

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions and medications.

DATE PATIENT SIGNATURE CHANGES TO HEALTH HISTORY DENTIST INITIALS

_____

_____

_____

_____

CONSENT TO DENTAL TREATMENT

Patient_____ DATE_____

I hereby authorize Dr _____and/or any such assistants as may be selected and supervised by him/her to provide me with dental treatment.

The nature, purpose and procedures of any proposed dental treatment will be explained to me so that I understand them.

The risks, benefits, and possible complications of any proposed treatment, including the risk that such treatment may not accomplish the desired objective, will be fully explained to me.

I understand that the success of dental treatment cannot be determined in advance and I acknowledge that no guarantees have been made to me regarding the results of treatment.

Should complications occur, I understand other procedures may be necessary .

I will be advised of the advantages and disadvantages of possible alternative treatments and my prognosis of treatment will be received. I will ask any questions I have regarding the nature, purpose and procedures and make sure they have been answered to my satisfaction.

I have had the opportunity to read this form, ask questions, and have had my questions answered to my satisfaction. I hereby consent to any proposed dental treatment.

_____ _____

Signature of Patient or Guardian. Date

CONSENT TO DENTAL TREATMENT

DAVID A. SESTERO, DDS, INC.

HIPAA NOTICE OF PRIVACY PRACTICES

YOUR PRIVACY RIGHTS
• To get an electronic or paper copy of your medical record and ask us to make corrections
• To request confidential communications and state a preferred method of contact (home or office phone, text message, mail or email)
• To ask us to limit what we use or share. We will say "yes" unless a law requires us to share that information or if it would affect your care
• To get a list of those with whom we've shared information
• To get a copy of this privacy notice
• To choose someone to act for you
• To file a complaint if you feel your rights are violated
OUR USES AND DISCLOSURES
• To treat you. We may share it with other professionals who are treating you
• To improve you care, manage your treatment and services
• To your health insurance plan so it will pay for the services provided to you
• To contribute to public health, safety issues and health research
• To comply with State and Federal Laws, including Department of Health and Human Services
• To respond to organ and tissue donation requests
• To collaborate with a coroner, medical examiner, or funeral director
• To respond to lawsuits and legal actions (in response to a court or administrative order, or a subpoena)
OUR RESPONSIBILITIES
• To maintain the privacy and security of your Protected Health Information (PHI)
• To inform you promptly if a breach occurs that may have compromised the privacy or security of your information
• To follow the duties and privacy practices described in this notice and give you a copy of it
• To not use or share your information other than as described here unless you tell us we can in writing

WE MAY CHANGE THE TERMS OF THIS NOTICE, AND THE CHANGES WILL APPLY TO ALL INFORMATION WE HAVE ABOUT YOU. THE NEW NOTICE WILL BE AVAILABLE UPON REQUEST, IN OUR OFFICE. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE HIPAA PRIVACY AND SECURITY OFFICER AT dentalinquiries@yahoo.com.

BY SIGNING THIS FORM YOU ACKNOWLEDGE RECEIPT OF DAVID A. SESTERO, DDS, INC. NOTICE OF PRIVACY PRACTICES

First Name:	Last Name:	If other than patient, relationship:
Signature:	Date:	