Patient Information

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Title: Mr. Ms. Mrs. **Gender: [ ] Male [ ] Female** **Family Status: [ ] Married [ ] Single [ ] Child [ ] Other**

Birth Date: _____ **Age:** _____ **SS#:** _____

Physical Address: _____ _____ _____ _____ _____
Street/P.O. Box Apt/Lot# City ST Zip Code

Mailing/Billing Address: _____ _____ _____ _____ _____
Street/P.O. Box Apt/Lot# City ST Zip Code

Phone: _____ _____ _____ _____ _____
Home Mobile Work EXT Other

Email Address: _____

I prefer to be contacted by: [ ] Cell Phone/Text [ ] Email [ ] Home Phone [ ] Other [ ] Can we leave a message?

The following is for: [ ] the patient [ ] the person responsible for payment [ ] other [ ] Not applicable

Employer Name: _____ **Occupation:** _____
Employer Address: _____
Emergency Contact: _____ _____ _____
Name Phone # Relationship

Name of person(s) we are authorized to discuss patient's treatment and account information?

_____

Primary Dental Insurance

Subscriber Name: _____
Subscriber DOB: _____
Subscriber SS#: _____
Phone #: _____
Relationship To Patient: _____
Insurance Plan Name: _____
Member ID#: _____

Secondary Dental Insurance

Subscriber Name: _____
Subscriber DOB: _____
Subscriber SS#: _____
Phone #: _____
Relationship To Patient: _____
Insurance Plan Name: _____
Member ID#: _____

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE:

Patient/Responsible Party Signature: _____ **Date:** _____

Medical History

Patient Name: _____ _____ _____
Last First MI

Indicate which of the following you have had or have at present. By checking the box, it will indicate a "Yes" response, leaving blank will indicate a "No" response.

[ ] *Premedicate
[ ] Acid Reflux
[ ] Adrenal Disorders
[ ] Allergies
[ ] Allergy – Peanuts
[ ] Allergy – Toradol
[ ] Allergy – Anesthetics
[ ] Allergy – Codeine
[ ] Allergy – Latex
[ ] Allergy – Penicillin
[ ] Alzheimer's/ Dementia
[ ] Anemia
[ ] Angina Pectoris
[ ] Anticoagulants
[ ] Anxiety
[ ] Arthritis
[ ] Artificial Joints
[ ] Asthma
[ ] Atrial Fibrillation
[ ] Birth Control Taken
[ ] Bleeding Disorders
[ ] Blood Disease
[ ] Blood Thinners
[ ] Bone Disorder
[ ] Cancer
[ ]Cirrhosis
[ ] Congenital Heart Defect
[ ] Convulsions
[ ] Defibrillator
[ ] Depression
[ ] Diabetes Type I/II
[ ] Dizziness/Fainting
[ ] Dyspnea on Exertion
[ ]Edema
[ ] Emphysema
[ ] Endocarditis, Bacteria
[ ] Epilepsy/Seizures
[ ] Excessive Bleeding
[ ] Fractures
[ ] GERD
[ ] Glaucoma
[ ] Growths/Tumors
[ ] Hay Fever
[ ] Head/Neck/Jaw Injury
[ ] Headaches/Migraines
[ ] Heart Arrythmia
[ ] Heart Attack
[ ] Heart Disease
[ ] Heart Murmur/MVP
[ ] Heart Valve Replacement
[ ] Hepatitis A/B/C
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Hyperthyroidism
[ ] Hypothyroidism
[ ] Jaundice
[ ] Kidney Disease
[ ] Kidney Infections
[ ] Leukemia
[ ] Liver Disease
[ ] Mental Disorders
[ ] Muscular Disorder
[ ] Myocardial Infarction
[ ] Nervous Disorders
[ ] Orthopnea
[ ] Other
[ ] Pacemaker/Stents
[ ] Paralysis
[ ] Parathyroid Disorder
[ ] Radiation/Chemo
[ ] Respiratory Problems
[ ] Rheumatic Fever
[ ] Rheumatic Heart Disease
[ ] Rheumatism
[ ] Shortness of Breath
[ ] Sinus Problems
[ ] STD/HPV
[ ] Steroids
[ ] Stomach Problems
[ ] Stroke
[ ] Thyroid Disorder
[ ] TMJ/TMD
[ ] Tuberculosis
[ ] Ulcers
[ ] Venereal Disease

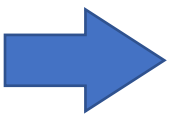
[ ] Are you pregnant at this time?

[ ] No Medical Conditions

[ ] No Health Changes

_____
INITIALS

CONT. NEXT PAGE



Please clarify the conditions or alerts selected including due date if you are pregnant:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain. [ ] YES [ ] NO

_____

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

_____

_____

Name of physician and date of last physical exam

_____

Are you taking any medications (prescription and non – prescription) If yes, please list below. [ ] YES [ ] NO

_____

_____

_____

_____

_____

_____

Do you have any allergies and/or allergies to medications? If yes, please list below. [ ] YES [ ] NO

_____

_____

_____

Please add any additional medical conditions you have that we did not cover.

_____

_____

_____

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. I further consent to the performing of radiographs (x-rays) and oral examinations.

_____ _____

Signature of Patient/Parent or Guardian **Date**

RENAISSANCE DENTAL, PC
VALENTIN A. FERRO, DMD
DENTIST-PATIENT AGREEMENT

I, THE PATIENT, UNDERSTAND THE FOLLOWING:

THE COST OF MY TREATMENT IS ULTIMATELY MY FINANCIAL RESPONSIBILITY.

IN THE EVENT THAT I FAIL TO MAKE FULL PAYMENT OF MY TREATMENT, I UNDERSTAND THAT THIS MATTER MAY BE REFERRED TO A COLLECTION AGENCY AND I WILL BE RESPONSIBLE FOR ALL FEES AND EXPENSES ASSOCIATED WITH SAID COLLECTION EFFORTS.

IF MY INSURANCE REQUESTS A REFUND OF THE AMOUNT THEY PAID TOWARD MY TREATMENT, I WILL REIMBURSE RENAISSANCE DENTAL, PC FOR THE AMOUNT OF SAID REFUND.

IF I CANNOT MAKE IT TO MY APPOINTMENT ON TIME, I AM EXPECTED TO CANCEL SAID APPOINTMENT WITHIN TWO (2) BUSINESS DAYS, OTHERWISE, I WILL BE BILLED A MISSED APPOINTMENT FEE. FOR EXAMPLE, AN 8:00 A.M. WEDNESDAY APPOINTMENT MUST BE CANCELLED NO LATER THAN 8:00 A.M. THE PREVIOUS MONDAY AND AN 8:00 A.M. MONDAY APPOINTMENT MUST BE CANCELLED NO LATER THAN 8:00 A.M. THE PREVIOUS THURSDAY IN ORDER NOT TO INCUR A MISSED APPOINTMENT FEE. MISSED APPOINTMENT FEES MAY RANGE FROM $100 TO $500 DEPENDING ON THE AMOUNT OF TIME ALLOTED AND THE NATURE OF THE APPOINTMENT. SAID FEE MUST BE PAID PRIOR TO RESCHEDULING THE APPOINTMENT.

Patient/Custodian Signature_____ **DATE**_____

Credit Card Information

OPTIONAL: If you would like for us to keep your credit card information on file for the payment of treatment, please list below.

CREDIT CARD # _____-_____-_____-_____ MC VISA AMEX DISC

Expiration Date: _____ V-Code_____

Name on Card: _____

I hereby authorize the use of my above listed credit card X_____

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I HEREBY GIVE CONSENT TO RENAISSANCE DENTAL, P.C., DR. VALENTIN A. FERRO, D.M.D., TO SEND TEXT MESSAGES, AND/OR EMAILS TO THE CELL NUMBER AND EMAIL ADDRESS LISTED ABOVE FOR APPOINTMENT REMINDERS AND TO SEND INFORMATION REGARDING REFERRALS TO A SPECIALIST, RECEIPTS FOR PAYMENTS MADE, INSURANCE INFORMATION, AND ANY OTHER INFORMATION ONCE I, THE PATIENT, GIVES THE OFFICE VERBAL CONSENT TO DO PRIOR TO SUBMISSION.

PATIENT SIGNATURE: _____ DATE: _____

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Arbitration

Satisfaction guarantee policy: Medical and dental services are not refundable. There will be no refund for ANY dental services, including but not limited to, crowns, bridges, partial dentures, fillings, inlays, onlays, radiographs, exams, cleanings, etc. Dr. Ferro will make every reasonable attempt to make clients/patients as satisfied with treatment as possible by adjusting and even remaking an item if Dr. Ferro deems necessary. Under no circumstances will this office be obligated to make a refund for ANY item.

ARBITRATION: Patient agrees that a claim, regardless of nature or kind, whether for negligence, contract, or personal injury, that patient may have or potentially have against Dr. Ferro or any employee or member of Dr. Ferro's staff, including the interpretation of this clause shall be submitted to and resolved by mandatory and binding arbitration in accordance with the statuses, rules or regulations of the American Arbitration Association (AAA); provided, however, that the forgoing reference to the AAA rules shall not be deemed to require any filing with that organization, nor any direct involvement of that organization. This arbitration provision shall be binding on the patient (purchaser) as well as any other person who claims to be a third-party beneficiary of this agreement.

Responsible Party's Signature: _____ Date:_____

Dental Patient Rights and Responsibilities Statement

Your dentist is the best source of information about your dental health and wants you to feel comfortable about your dental care. Maintaining healthy teeth and gums means more than just brushing and flossing every day and visiting your dentist regularly. As an informed dental patient, it also means knowing what you can expect from your dentist and dental care team and understanding your role and responsibilities in support of their efforts to provide you with quality oral health care.

The rights and responsibilities listed below do not establish legal entitlements or new standards of care, but are simply intended to guide you through the development of a successful and collaborative dentist-patient relationship.

Patient Rights

1. You have a right to choose your own dentist and schedule an appointment in a timely manner.
2. You have a right to know the education and training of your dentist and the dental care team.
3. You have a right to arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.
4. You have a right to adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.
5. You have the right to know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.
6. You have a right to an explanation of the purpose, probable (short and long term) results, alternatives and risks involved before consenting to a proposed treatment plan.
7. You have a right to be informed of continuing heath care needs.
8. You have a right to know in advance the expected cost of treatment.
9. You have a right to accept, defer or decline any part of your treatment recommendations.
10. You have a right to reasonable arrangements for dental care and emergency treatment.
11. You have a right to receive considerate, respectful and confidential treatment by your dentist and dental team.
12. You have a right to expect the dental team members to use appropriate infection and sterilization controls.
13. You have a right to inquire about the availability of processes to mediate disputes about your treatment.

Patient Responsibilities

1. You have the responsibility to provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.
2. You have the responsibility to report changes in your medical status and provide feedback about your needs and expectations.
3. You have the responsibility to participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.
4. You have the responsibility to inquire about your treatment options and acknowledge the benefits and limitations of any treatment that you choose.
5. You have the responsibility for consequences resulting from declining treatment or from not following the agreed upon treatment plan.
6. You have the responsibility to keep your scheduled appointments.
7. You have the responsibility to be available for treatment upon reasonable notice.
8. You have the responsibility to adhere to regular home oral health care recommendations.
9. You have the responsibility to assure that your financial obligations for health care received are fulfilled.

Patient Acknowledgment:

Thank you very much for taking the time to review how we are carefully using your health information. I you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this information and returning it to us. Please request copies and one will be provided to you.

_____ _____

Patient Signature Date