Palumbo Family Dentistry

Charles H. Palumbo DDS, PC FAGD

Patient Registration

Patient's Name _____ Date of Birth _____

Home Address _____ City _____ State_____ Zip_____

Home # ( )_____ Work ( )_____ Cell ( )_____

Patient's Soc Sec # _____

- Email Address (Appointment Reminders) _____

Physician's Name _____

City _____ State _____ Telephone ( )_____

Insured's Date of Birth _____/_____/_____

Insured's Name _____ Relationship to Patient _____

Dental Insurance Company _____ Employer _____

ID # or SSN of Insured _____ Group # _____

CONSENT

The undersigned hereby authorizes Doctor and/or his assigned staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk.

I understand that the responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered, unless financial arrangements have been made. I further understand that a finance charge could be added to any overdue balance and that accounts due over 90 days may be assigned to a collection agency. I also assign all insurance benefits to the Doctor. In Addition, permission is granted to divulge dates of service and services rendered but not paid for, to coordinate dental benefits.

The undersigned also agrees to allow Doctor or his assigned staff to discuss relevant medical or dental information necessary to coordinate any healthcare issue with other medical personnel and to divulge any necessary information pertinent to insurance claims with third-party carriers.

I understand missed appointments, or appointments not cancelled within one business day prior to the appointment time are subject to a fee. I also understand that my portion is due in full at the time of service.

While the filling of dental insurance claims is a courtesy that we extend to our patients, all charges are the responsibility of the patient, presenting parent, or guardian from the date such services are rendered.

PATIENT, PARENT OR GUARDIAN _____ DATE _____

DENTIST'S SIGNATURE _____ DATE_____

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MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Do you have, or have you had, any of the following?

( ) Alzheimer's	( ) AIDS/HIV Positive	( ) Arthritis
( ) Artificial Joints	( ) Black Stools	( ) Bleeding Disorders
( ) Blood in Urine	( ) Cancer	( ) Convulsions
( ) Diabetes	( ) Dizzy/Fainting Spells	( ) Emotional Problems
( ) Heart Trouble	( ) Hepatitis	( ) High Blood Pressure
( ) Hives/Hay Fever	( ) Kidney Disease	( ) Leukemia
( ) Liver Disease	( ) Lung Disease	( ) Mumps/Measles
( ) Physical Handicap	( ) Radiation Treatment	( ) Rheumatic Fever
( ) Scarlet Fever	( ) Severe Headaches	( ) Shingles/Chicken Pox
( ) Sickle Cell Disease	( ) Sores in/on Lips or Mouth	( ) Steroids
( ) Stomach Disease	( ) Stroke	( ) Thyroid Disease
( ) Tuberculosis	( ) Tumors	( ) Venereal Disease

( ) Have you ever had any serious illness not listed above?

_____

Are you currently taking any medications? Please List:_____

_____

Do you have any allergies to medications? _____

Do you use herbal compounds of any kind? _____

Women Only

Are you pregnant? Y/N

Are you using birth control? Y/N

Dental History

How long has it been since a dentist last saw you? _____

Are you having any problems now? _____

Do you clench or grind? Y/N

Have you ever had excessive bleeding following an extraction? Y/N

Have you ever become sick due to dental treatment? Y/N

Have you ever had an injury to your face or teeth? Y/N

Are your teeth sensitive to hot or cold? Y/N

Whom may we thank for referring you to our office? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

PRINT PATIENTS NAME _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____**DATE**_____

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Patient Communication Preferences

To Our Valued Patients:

We are updating our records to determine the best way to communicate with you regarding treatment and appointments in our practice.

Please let us know your preferred method of receiving messages from us:

☐ Cell Phone - Number: _____

☐ Home Phone - Number: _____

☐ Work Phone - Number: _____

☐ Email: _____

May we send e-mail messages to you regarding your appointments? Yes___ No___

* Note if email is selected for appointment reminders that this is a nonsecure form of communication. We will not disclose protected healthcare information in these e-mail communications. By selecting e-mail as a form of appointment reminder communication you are agreeing to the above security disclosure.

In the event you cannot be reached by phone, is there someone we may leave a message with? (e.g. spouse, partner) Name: _____

Relationship: _____ Phone number: _____

_____ _____

Patient Name (printed) Signature

_____

Date

Stay up to date with our office by following us on Facebook.

Facebook.com/PalumboFamilyDentistry

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