Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____

FOR OFFICE USE ONLY

Patient Name: _____ _____ _____ _____

Last First MI Preferred Name

Title: _____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Other

Mr/Ms/Mrs/etc.

Birth Date: _____ Prev. Visit: _____ E-Mail: _____

Phone: _____ _____ _____ _____

Home Work Ext. Mobile

Best time to call: _____

Address: _____

_____ _____ _____

City State Zip Code

Preferred appointment times:

☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat

☐ Morning ☐ Afternoon ☐ Evening ☐ Any time

Whom may we thank for referring you to

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper

☐ School ☐ Work ☐ Other (name below)

VICTOR J. BUCCELLATO. DMD, PA

Health Information

Date of Last Dental Visit: _____

Have you ever had any of the following? Please check all that apply:

- ○ AIDS
- ○ Allergies _____ _____
- ○ Arthritis
- ○ Artificial Joints
- ○ Asthma
- ○ Blood Disease
- ○ Cancer
- ○ Diabetes
- ○ Dizziness
- ○ Epilepsy
- ○ Excessive Bleeding
- ○ Fainting
- ○ Glaucoma
- ○ Growths
- ○ Hay Fever
- ○ Head Injuries
- ○ Heart Disease
- ○ Heart Murmur
- ○ Hepatitis
- ○ High Blood Pressure
- ○ Jaundice
- ○ Kidney Disease
- ○ Liver Disease
- ○ Mental Disorders
- ○ Nervous Disorders
- ○ Pacemaker
- ○ Pregnancy Due Date_____
- ○ Radiation Treatment
- ○ Respiratory Problems
- ○ Rheumatic Fever
- ○ Rheumatism
- ○ Sinus Problems
- ○ Stomach Problems
- ○ Stroke
- ○ Tuberculosis
- ○ Tumors
- ○ Ulcers
- ○ Venereal Disease
- ○ Codeine Allergy
- ○ Penicillin Allergy
- ○ OTHER
- ○ _____
- ○ _____

Have you ever had any complications following dental treatment? ☐ YES ☐ NO

If yes, please explain: _____

Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐ YES ☐ NO

If yes, please explain: _____

Are you under the care of a physician? ☐ YES ☐ NO

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ☐ YES ☐ NO

If yes, please explain: _____

Current Prescription Medications Used

Name of the medication	Dosage	Frequency	Taken last on?	Taken regularly?	Allergic reactions or Side Effects	Prescribed For
			/ /			
			/ /			
			/ /			
			/ /			
			/ /			
			/ /			

Spouse or Responsible Party Information

The following is for: ☐ The patient's spouse ☐ The person responsible for payment ☐ Neither – N/A

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Other
Mr/Ms/Mrs/etc.

Birth Date: _____ E-Mail: _____

Phone: _____ _____ ___ _____
Home Work Ext. Mobile

Best time to call: _____

Address: _____

_____ ___ _____
City State Zip Code

Employment Information

The following is for: ☐ The patient ☐ The person responsible for payment

Employer Name: _____

Address: _____

_____ ___ _____
City State Zip Code

Primary Insurance Information

Primary Dental Insurance

Name of Insured:

Last First MI

Insured's Birth Date: ID#:

Group#:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Address:

City State Zip Code

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Secondary Insurance Information

Secondary Dental Insurance

Name of Insured:

Last First MI

Insured's Birth Date: ID#:

Group#:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Address:

City State Zip Code

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the cost incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, within five (5) day of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party) Date:

_____

Relationship to Patient:

Response Date: