CLIFTON PARK DENTAL

Joseph Roberto | Traci Delwo | Gary Iuliano
5 Emma Lane. Clifton Park, NY, 12065
P: (518)-371-8206 F: (518)-371-0479

MEDICAL HISTORY

Patient Name: _____ Birthdate: _____

Are you under the care of a primary physician? ☐ **Yes** ☐ **No**

Doctor:_____ Phone: _____

Have you ever been hospitalized or have had any major operations? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Do you have any orthopedic total joint replacements? ☐ **Yes** ☐ **No**

If yes, please explain: _____

***If so, do you require antibiotics before dental treatment for a joint replacement or any other medical purpose? ☐ **Yes** ☐ **No** What kind of antibiotic? _____

Do you or have you taken oral medications or received IV treatment for osteoporosis?

☐ **Yes** ☐ **No**

If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Have you taken Fen-Phen or Redux? ☐ **Yes** ☐ **No**

Do you use tobacco? ☐ **Yes** ☐ **No**

Do you use controlled substances? ☐ **Yes** ☐ **No**

Do you drink alcoholic beverages? ☐ **Yes** ☐ **No**

WOMAN ONLY: Are you; ☐ Trying/Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Allergies: Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

Other? please explain: _____

Preferred Pharmacy

Pharmacy Name:_____

Address:_____ Phone Number: _____

OVER →

Medications: Please list any medications that you are currently taking:

_____

_____

_____

_____

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

Cardiac (Heart)

- ☐ Pacemaker
- ☐ Artificial Heart Valve
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Arteriosclerosis
- ☐ Irregular Heartbeat
- ☐ Rheumatic Heart Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Stroke
- ☐ Mitral Valve Prolapse
- ☐ Angina

Respiratory (Breathing)

- ☐ Asthma
- ☐ Breathing Problems
- ☐ Easily Winded
- ☐ Lung Disease
- ☐ Emphysema
- ☐ Frequent Cough
- ☐ Sinus Trouble
- ☐ Tuberculosis

Cancer

Type:_____

Date of diagnosis:_____

- ☐ Chemotherapy
- ☐ Radiation Treatment

Circulatory (Blood)

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Anemia
- ☐ Hemophilia
- ☐ Blood Transfusion
- ☐ Blood Disease
- ☐ Excessive Bleeding

Neurological (Brain)

- ☐ Epilepsy or Seizures
- ☐ Psychiatric Care
- ☐ Frequent Headaches
- ☐ Alzheimer's Disease
- ☐ Anxiety

Vision

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Blind

Autoimmune Disease

- ☐ AIDS/HIV Positve
- ☐ Lupus
- ☐ Sickle Cell Disease

Digestive

- ☐ Ulcers
- ☐ Gastrointestinal Disease
- ☐ Frequent Diarrhea
- ☐ Acid Reflux

Other

- ☐ Fainting Spells/ Dizziness
- ☐ Kidney Problems
- ☐ Thyroid Disease
- ☐ Rheumatic Fever
- ☐ Hives or Rash
- ☐ Bruise Easily
- ☐ Pain in Jaw Joints
- ☐ Herpes
- ☐ Hepatitis
- ☐ Arthritis/Gout
- ☐ Drug Addiction
- ☐ Cold Sores/Fever Blisters
- ☐ Shingles
- ☐ Parathyroid Disease
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Venereal Disease
- ☐ Spina Bifida
- ☐ Swelling of Limbs
- ☐ Tonsillitis
- ☐ Convulsions
- ☐ Yellow Jaundice
- ☐ Recent Weight Loss
- ☐ Diabetes
- ☐ Hay Fever/Seasonal
- ☐ Osteoporosis
- ☐ Anaphylaxis
- ☐ Tumors or Growths
- ☐ Liver Disease
- ☐ Renal Dialysis
- ☐ Excessive Thirst
- ☐ Artificial Joint
- ☐ Cortisone Medicine
- ☐ Chest Pains

If any, please list any illness, disease, or health issue not listed above:

_____

_____

_____

The form has been accurately filled out to the best of my knowledge, and I acknowledge the importance of providing correct information for health safety. It is my duty to update the dental office about any changes in medical status.

_____

Print Name

_____ _____

Signature/Legal Guardian Date

CLIFTON PARK DENTAL

Joseph Roberto | Traci Delwo | Gary Iuliano
5 Emma Lane Clifton Park, NY, 12065
P: (518)-371-8206 F: (518)-371-0479

PATIENT REGISTRATION

Patient Name: _____ Preferred Name: _____

Sex: ☐ **M** ☐ **F** SSN : _____ Birthdate: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separted ☐ Long Term Partner

Email Address: _____

In case of emergency, who should we contact?

Name: _____ Phone:_____ Relationship:_____

How did you hear about us? ☐ Online ☐ Friend/Family ☐ Current Patient ☐ Phone Book

Current patient referred you? Who should we thank? _____

Please provide all of your insurance information accurately in order for us to submit your claim properly. We are not responsible for any misinformation or denial from your insurance company. Any changes to insurance information, we must be made aware immediately for timely filing.

PRIMARY INSURANCE

Policy Holder: _____ Birthdate: _____ Relationship: _____

Insurance Company: _____ Employer: _____

Member ID #: _____ Group #: _____ Phone #: _____

Claims Address: _____
Street City State Zip

OVER →

SECONDARY INSURANCE

Policy Holder: _____Birthdate: _____ Relationship: _____

Insurance Company: _____ Employer: _____

Member ID #: _____Group #: _____Phone #: _____

Claims Address: _____
Street City State Zip

I hereby authorize payment directly to Jospeh and Traci A, Roberto DDS, PLLC of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor/or any provider or supplies of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Print Name

_____ _____
Signature/Legal Guardian Date

CLIFTON PARK DENTAL

Joseph Roberto | Traci Delwo | Gary Iuliano
5 Emma Lane Clifton Park, NY, 12065
P: (518)-371-8206 F: (518)-371-0479

DENTAL HISTORY

Name: _____ Date of Birth:_____

How would you rate the condition of your mouth? ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

When was your most recent dental visit? _____

What did you have done at your last appointment? Check all that apply: ☐ **Exam** ☐ **Cleaning** ☐ **X-rays**

How routinely do you visit the dentist? Every; ☐ **3 mo.** ☐ **4 mo.** ☐ **6 mo.** ☐ **12 mo.** ☐ **Not Routinely**

What is your immediate concern? _____

Please answer YES or NO to the following questions:

PERSONAL HISTORY	**YES**	**NO**
Have you had an unfavorable dental experience? _____	☐	☐
Have you ever had complications from past dental treatment? _____	☐	☐
Have you ever had trouble getting numb or any reactions to local anesthetics? _____	☐	☐
Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
SMILE CHARACTERISTICS		
Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
Have you ever whitened (bleached) your teeth? _____	☐	☐
Have you felt uncomfortable or self-conscious about the appearance of your teeth?_____	☐	☐
Have you been disappointed with the appearance of previous dental work? _____	☐	☐
BITE AND JAW JOINT		
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping? _____	☐	☐
Have your teeth changed in the last 5 years, becoming shorter, thinner, or worn? _____	☐	☐
Are your teeth crowding or developing spaces?_____	☐	☐
Do you have more than one bite and squeeze to make your teeth fit together? _____	☐	☐
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
Do you clench your teeth in the daytime or make them sore? _____	☐	☐
Do you have any problems with sleep or wake up with an awareness of your teeth?_____	☐	☐
Do you wear or have you ever worn a bite appliance?_____ _____	☐	☐
TOOTH STRUCTURE		
Do you feel or notice any holes on the biting surface of your teeth? _____	☐	☐
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing part of your mouth? _____	☐	☐
Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
Do you frequently get food caught between any teeth? _____	☐	☐
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?_____	☐	☐
GUM AND BONE		
Do your gums bleed or are they painful when brushing or flossing?_____ _____	☐	☐
Have you ever been treated for gum disease or been told you have lost bone around your teeth?_____	☐	☐
Have you ever noticed an unpleasant taste or odor in your mouth?_____	☐	☐
Is there anyone with a history of periodontal disease in your family?_____ _____	☐	☐
Have you ever experienced gum recession?_____ _____	☐	☐
Have you ever had any teeth become loose on their own (without an injury)?_____	☐	☐
Have you experienced a burning sensation in your mouth?_____	☐	☐

_____ _____
Signature/Legal Guardian Date

CLIFTON PARK DENTAL

Joseph Roberto | Traci Delwo | Gary Iuliano
5 Emma Lane Clifton Park, NY, 12065
P: (518)-371-8206 F: (518)-371-0479

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing, we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITES IN THE FUTURE.

_____ _____
Please *print* name of PATIENT Please sign name of PATIENT/GUARDIAN of patient

_____ _____
Legal Representative/Guardian Relationship of Legal Representative/Guardian

Date:_____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION.

NAME:_____ RELATIONSHIP: _____

NAME:_____ RELATIONSHIP: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO:

CONFIRM APPOINTMENTS, DISCUSS TREATMENT, & BILLING VIA

☐ **Cell Phone** ☐ **Home Phone** ☐ **Work Phone**

☐ **Text Message** ☐ **Email** ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

☐ It was emergency treatment

☐ I could not communicate with the patient

☐ The patient refused to sign

☐ Other (please describe)_____

Signature of Privacy Officer: _____ Date:_____

CLIFTON PARK DENTAL

Joseph Roberto | Traci Delwo | Gary Iuliano
5 Emma Lane Clifton Park, NY, 12065
P: (518)-371-8206 F: (518)-371-0479

OFFICE POLICY

At Clifton Park Dental, our primary objective is to deliver exceptional dental care to our patients. The following outlines our Office Policies for your reference.

Payment for all dental services and procedures is expected on the day of service. We accept various payment methods, including major credit cards. Additionally, we have partnered with third-party financing options that offer low monthly payment plans for eligible individuals.

Please note that our providers are not affiliated with any specific insurance companies. Consequently, we cannot guarantee the exact benefits your insurance provider may cover. While we strive to assist you in estimating your out-of-pocket expenses, we do not guarantee insurance coverage. As a service to our patients, we promptly submit claims on the day of your appointment.

For appointments that are scheduled for two hours or longer, a $100 deposit is required to secure the treatment slot. This deposit will be deducted from the total treatment cost.

In the event that you need to reschedule or cancel your appointment, we kindly request a minimum of two business days' notice. Failure to provide this notice may result in a missed appointment fee or forfeiture of any deposit held on your account. Should you late cancel or miss three appointments, future appointments may be scheduled on a "quick call" basis only.

I have read, understand, and agree to the above Office Policy statement:

_____
Print Name

_____ _____
Signature/Legal Guardian Date