LIPARI MANGIAMELI

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care and make each of your visits pleasant and comfortable. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name ______________________ Date ______________

Soc. Sec. # ______________ Birthdate ______________ Home Phone ______________

Address ______________ City ______________ State ________ Zip ________

Email ______________________ Cell Phone ______________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer ______________________ Work Phone ______________

Whom May We Thank for Referring You? ______________________

Person to Contact in Case of Emergency ______________________ Phone ______________

Responsible Party

Name of Person Responsible for this Account ______________________ Relationship to Patient ______________

Address ______________________ Home Phone ______________

Email ______________________ Cell Phone ______________

Driver's License # ______________ Birthdate ______________ SS# ______________

Employer ______________ Work Phone ______________

Is This Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Dental Insurance

Your dental plan is a form of compensation provided by your employer. You can expect the carrier insurance company to reimburse you for a portion of our fee. That portion is determined by the contract between your employer and the insurance company. The higher the premium paid by your company, the more generous the reimbursement.

Although we are not a party to the contractual arrangement with your insurance company, we do want to help you receive the maximum reimbursement to which you are entitled. As a convenience to you we will help you process your insurance claims in order for you to receive this maximum benefit. We will also gladly provide dental x-rays and a written diagnostic report should your insurance company have any questions about the services provided. Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage.

At all times, you can be confident that we will always provide you with our best services without regard to the limitations imposed by your insurance coverage.

Name of Insured ______________________ Relationship to Patient ______________

Birthdate ________ SS# ______________ Date Employed ______________

Name of Employer ______________ Union or Local # ________ Work Phone ______________

Employer Address ______________ City ______________ State ________ Zip ________

Insurance Company ______________ Group # ______________ Policy/ID# ______________

Ins. Co. Address ______________ City ______________ State ________ Zip ________

Do You Have Any Additional Insurance? ☐ Yes ☐ No

Over Please

Patient Medical History

Physician ______________________ Office Phone ______________ Date of Last Exam ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you allergic to or have you had any reactions to the following:		
Local Anesthetics (e.g. novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other ______________________	☐	☐
11. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other ______________	☐	☐

Patient Dental History

Name of Previous Dentist and Location ______________________ Date of Last Exam ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Does your child: suck thumb / finger bite / chew nails?	☐	☐
12. Do you participate in contact sports?	☐	☐
13. Have you ever had any difficult extractions in the past?	☐	☐
14. Have you ever had any prolonged bleeding following extractions?	☐	☐
15. Have you had any orthodontic treatment?	☐	☐
16. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________		
17. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
18. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize and request the dentist or office staff to create photographic communication. I authorize the doctor to release any information including the diagnosis and the records of images of my face and teeth for the purposes of documentation and professional any treatment or examination rendered to me or my child during the period of such health care to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event that my payments are not received within 30 days of treatment, I agree to pay all costs of collections including but not limited to reasonable attorney's fees.

X ______________________

Signature of patient (or parent/guardian if minor)

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Signature of Dentist Date

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