PATIENT'S DENTAL HISTORY

PATIENT'S NAME ______________________________ DATE OF BIRTH ______________

REASON FOR THIS VISIT ______________________________

WHEN WAS YOUR LAST DENTAL VISIT ______________ WHAT WAS DONE THEN ______________

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN ______________________________

PREVIOUS DENTIST (NAME AND LOCATION) ______________________________

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE ______________

HOW OFTEN DO YOU BRUSH YOUR TEETH ______________ HOW OFTEN DO YOU FLOSS YOUR TEETH ______________

IS YOUR DRINKING WATER FLUORIDATED ______________________________

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	☐	☐
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	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE.	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT ______________		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? ______________________________

____

____

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 AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X ______________________________ DATE ______________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS ______________________________

____

______________ SIGNATURE ______________________________ DATE ______________

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____

PATIENT'S NUMBER

HEALTH HISTORY

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME ______________________________ DATE OF BIRTH ______________

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 THAT YOU WILL BE RECEIVING.

	YES	NO
1. ARE YOU IN GOOD HEALTH	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM: ______		
4. PHYSICIAN'S NAME ______		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS	☐	☐
PLEASE EXPLAIN. ______		
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE	☐	☐
IF YES, WHAT MEDICINE(S) ARE YOU TAKING ______		
8. HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
9. DO YOU BRUISE EASILY	☐	☐
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION		
11. HAVE YOU HAD A RECENT WEIGHT LOSS	☐	☐
12. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES	☐	☐
13. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LEVITRA IN THE LAST 24 HOURS	☐	☐
14. DO YOU SMOKE OR CHEW TOBACCO	☐	☐
15. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	☐	☐
HOW MUCH DAILY? ______		
17. ARE YOU WEARING CONTACT LENSES	☐	☐
18. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	☐	☐
19. DO YOU HAVE ANY DISEASE, OR PROBLEM NOT LISTED THAT YOU THINK I SHOULD KNOW ABOUT	☐	☐
20. HAVE YOU EVER BEEN TOLD YOU NEED TO TAKE ANTIBIOTICS BEFORE DENTAL TREATMENT?	☐	☐

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT YES / NO ARE YOU NURSING YES / NO ARE YOU TAKING BIRTH CONTROL PILLS YES / NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX / RUBBER	☐	☐
OTHER (PLEASE LIST) ______		

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA	☐	☐
CHEST PAIN	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SHORTNESS OF BREATH	☐	☐
SINUS TROUBLE	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES SEASONAL/FOOD	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
EATING DISORDERS	☐	☐
	☐	☐

ALISON M. SCAVUZZO DMD, FAGD

Welcome to our practice! **Our primary concern is always your health and dental well-being**. We would like to take a moment to share important information with you. Our office is happy to help you file your insurance claims to receive benefits for which you and your employer are paying premiums. **Dental plans vary greatly. Different procedures may be covered or not covered depending upon individual plan benefit**. Insurance companies make payment based on restricted fee schedules. **Regardless of what the actual fees may be, your insurance plan will only pay what it allows for each service. Deductibles, co-payments, and alternate benefit clauses are typically built into plans, as are benefit frequency limitations (i.e. x-ray benefits) Required patient payment to doctors for deductibles and co-payments etc. is strictly regulated by law. Ins companies have benefit restrictions regarding time limits on radiographs (x-rays). We explain during the initial conversation (at the time your appt was set up) that it is imperative that you inquire at any previous dental office(s) to obtain duplicates of current radiographs. You may be required to sign a release to obtain them. IF you do not have copies for us at your first appt, it is necessary to take new x-rays today that may not be covered by your insurance. Your Human Resources director or insurance company can help familiarize you with your benefits and plan restrictions. We will gladly assist you in maximizing and understanding your benefits.**

We will gladly:

1. Complete your insurance claims and submit them to your carrier in a timely manner.
2. Accept payment, where applicable, from your insurance carrier and accurately track balances.
3. If necessary, we will happily re-file your unpaid ins. claim a second time within a 60 day period.

We ask you:

1. **To please pay any deductibles and co-payments at the time of treatment**. Any balance remaining after insurance payment is due within 30 days and must be paid in full upon receiving a phone call. We are cutting back on statements when possible due to rising costs of billing. **Please note that a statement will not be sent to you until after ALL claims (for all persons on your account) are paid. FULL balance is due upon receipt of FIRST bill. Your account will age while claims are pending with ins. We do not consider you past due until 30 days after the receipt of the FIRST statement. Non-insurance patients must pay in full for services rendered at the time of service**. All major credit cards are accepted for your convenience. Personal checks are welcome. We also offer financing options through CareCredit.
2. To provide our office with the necessary information concerning your insurance coverage to allow for correct filing of claims. Please make us aware of any changes of insurance carrier prior to treatment so that we may keep you well informed.
3. To understand that your plan is a contract between you, your employer, and the insurance carrier.
4. Please contact your insurance company when claim payment has not been made within 60 days.
5. We ask that you pay all balances not paid by your insurance company right away.. **You are ultimately responsible for all balances not paid by insurance. Please note: We make every effort to keep our patients informed, however it is every patients responsibility to know if we are in or out of network for their particular carrier. If you are unsure, please ask us if we are a participating or non-participating provider with your insurance carrier.**
6. Please value your reserved appointment as we value you as our patient. If you are unable to keep an appt we ask that you notify us at least **two business days prior to the scheduled appointment.**
7. Per PA state law, if treatment you opt to have is a non-covered benefit, alternate benefit, beyond your annual max benefit or your ins allows coverage for BASIC materials only, you acknowledge that you accept full financial responsibility for the full fee associated with your treatment beyond what your ins company allows. **The Commonwealth of PA prohibits insurance companies from determining fees on non-covered or alternate services.**

Dr. Scavuzzo employees licensed Expanded Function Dental Assistants (EFDA). Similar to a Physician's Assistant EFDA's have specialized training to assist the doctor with procedures. There are many procedures they perform in concert with Dr. Scavuzzo.

We thank you for choosing us to serve your dental needs. We will do all we can to help you obtain the benefits you deserve and to provide you with the highest standard of care. Please sign below. We will keep this in your file and give you a copy upon request for your records.

I understand that I am responsible for payment of all costs of dental treatment. I grant the right to release my medical/dental records and other information concerning my dental treatment to third party payers.

Signature____ **Date**__________

INFORMED CONSENT

By signing below I understand this is an agreement in writing between me and Dr. Alison M. Scavuzzo as to the information that follows. I understand that I have the right to be involved in my dental treatment decisions and have been asked to take an active role in being informed.

Dr. Scavuzzo informs every patient of proposed treatment as well as any reasonable alternative treatments that are possible in each individual situation. Dr. Scavuzzo will answer questions regarding the clinical aspects of treatment. Front office staff will address any questions regarding fees, insurance, and out-of-pocket costs relating to the treatment you choose.

Insurance allowances for insurance plan benefits have increased nominally in the past decade while the costs associated with dental procedures have increased substantially. **Dr. Scavuzzo's participation with insurance companies causes fee allowances to be reduced by your insurance company. At this time adding Materials Fees for some dental services is the only way to continue to provide the highest level of dental care. We strive to inform you regarding all costs pertaining to your treatment in advance but we ask for your help by encouraging you to ask questions pertaining to your treatment**. **Insurance plans are structured to allow coverage for only the most basic materials to be used in procedures. Due to the nature of these restrictions some procedures may require an additional materials fee. This fee WILL add to the patient out-of-pocket cost. This is because in providing quality dentistry Dr. Scavuzzo chooses to use only the highest quality materials and exceptional laboratories. The laboratories we use do not outsource to China or any other country.** The result of NOT charging this fee would be dropping participation with PPO plans which would have an effect on every procedure you have to include preventive care (cleanings/exams/X-rays).

We will gladly provide you with any fee information and direct you to your insurance company if necessary. **PLEASE ask questions! By signing below you are accepting the responsibility of asking questions in advance of your treatment so that we may help you to understand your insurance and its limitations prior to treatment you have chosen to accept as well as prior to incurring a balance due**. Dr. Scavuzzo and the entire staff care about you, your oral and overall health, and all aspects of your treatment. We ask that you help us to help you in making treatment decisions and understanding the costs involved in advance of treatment.

Print name____

Signature____Date________________________

Alison M. Scavuzzo DMD, FAGD
1260 Freedom Crider Rd
Freedom, PA 15042

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of privacy practices (HIPPA) required of all health care providers. We follow all laws pertaining to your private information. Federal law requires us to notify our patients that your information can and may be used in accordance with federal law to submit claims and other correspondence to your insurance companies. Your information in the form of radiographs (x-rays) will be provided to a specialized doctor that we are referring you to such as an Orthodontist or Oral Surgeon etc. We will never share your private information with anyone other than your insurance carrier or healthcare professional.

COMPLAINTS

If you think we have not properly respected the privacy of your health information, you are free to complain to us directly or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you wish to complain to us, send a written complaint to the doctor at the address listed above. Your issues will be addressed with you in person or by phone.

FOR MORE INFORMATION

If you need further information regarding our privacy practices, call or direct questions in person to front office staff.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Patient name____

Signature____**Date**____________

PATIENT INFORMATION (CONFIDENTIAL)

NAME ______ (FIRST / MI / LAST) ______ DATE ______

ADDRESS ______ CITY ______ STATE ______ ZIP ______

SS#/SIN ______ CELL PHONE ______ HOME PHONE ______

BIRTHDATE ______ E-MAIL ______

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT'S EMPLOYER ______ WORK PHONE ______

SPOUSE OR PARENT'S NAME ______

RELATIONSHIP TO CONTACT ______

WHOM MAY WE THANK FOR REFERRING YOU? ______

PERSON TO CONTACT IN CASE OF AN EMERGENCY ______ PHONE ______

IF COLLEGE STUDENT - NAME OF SCHOOL ______ ☐ PT ☐ FT

RESPONSIBLE PARTY (SKIP IF SAME AS ABOVE)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______ RELATIONSHIP TO PATIENT ______

ADDRESS ______ HOME PHONE ______

SS # ______ BIRTHDATE ______ CELL PHONE ______

EMPLOYER ______ WORK PHONE ______

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ______ RELATIONSHIP TO PATIENT ______

SS # ______ BIRTHDATE ______

NAME OF EMPLOYER ______ WORK PHONE ______

EMPLOYER ADDRESS ______ CITY ______ STATE ______ ZIP ______

INSURANCE CO. ______ TEL. # ______ GRP # ______ POLICY / I.D. # ______

INS. CO. ADDRESS ______ CITY ______ STATE ______ ZIP ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ______ RELATIONSHIP TO PATIENT ______

SS # ______ BIRTHDATE ______

NAME OF EMPLOYER ______ WORK PHONE ______

EMPLOYER ADDRESS ______ CITY ______ STATE ______ ZIP ______

INSURANCE CO. ______ TEL. # ______ GRP # ______ POLICY / I.D. # ______

INS. CO. ADDRESS ______ CITY ______ STATE ______ ZIP ______

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X ______
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

______
PATIENT NUMBER

REGISTRATION