Patient Information

Name _____

SS/HIC/Patient ID #_____

Date_____

Address_____

City_____

State _____ Zip_____

E-mail_____

Sex ☐M ☐F Age _____

Birth date _____

☐ Married ☐ Widowed ☐ Single ☐Minor
☐ Separated ☐ Divorced ☐ Partnered for_____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____)_____

Spouse's Name _____

Birthdate_____

SS#_____

Spouse's Employer_____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account _____

Relationship to Patient _____

Insurance Co. _____

Group #_____
Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name _____

Birthdate _____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to
Name of company(ies)

Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature

_____
Please print name

_____ _____
Date Relationship to Patient

Phone Numbers

Home (____)_____ Work (____)_____ Ext____Cell Phone (____)_____

Spouse's Work (____)_____ Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship _____

Home (____)_____ Work (____) _____

Dental Health History:

Correct answers to the following questions will allow Dr. Gecovich to treat you on a more individual basis, providing the care appropriate for your particular needs. Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
Do you like your smile? If not why? _____	☐	☐
Last known x-rays taken? _____		
Last visit to the Dentist? _____		
Gum Pain/Bleeding.....	☐	☐
Do you have a history of Gum Disease?.....	☐	☐
Jaw Pain ?.....	☐	☐
Do you smoke?.....	☐	☐
Do you have pain when you bite?.....	☐	☐
Have you ever had a joint replaced?.....	☐	☐
How often do you floss? _____		
How often do you brush?_____		

Health History:

Correct answers to the following questions will allow Dr. Gecovich to treat you on a more individual basis, providing the care appropriate for your particular needs. Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
Are you in good health now?	☐	☐
Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____	☐	☐
Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, explain _____	☐	☐
Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
(Women) Are you pregnant? If so, give due date _____	☐	☐
(Women) Are you on birth control medication? _____	☐	☐
Do you use tobacco in any form? If yes, how much _____	☐	☐

Do you have any of the following?

GENERAL

	YES	NO
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐

SKIN

Eruptions (rash) hives	☐	☐
Change in skin color	☐	☐

EYES

Visual change	☐	☐
Glaucoma	☐	☐

EARS

Loss of hearing	☐	☐
Ringing in ears	☐	☐

NOSE

Frequent nosebleeds	☐	☐
Sinus problem	☐	☐

THROAT

Soreness/hoarseness	☐	☐

NERVOUS SYSTEM

Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐

RESPIRATORY

Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐

ENDOCRINE

Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐

Other _____

HEART/BLOOD VESSELS

	YES	NO
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐

Other _____

BONE/MUSCLES

Arthritis/rheumatism	☐	☐
Artificial joints	☐	☐

DIGESTIVE SYSTEM

Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
Black, bloody or pale stools	☐	☐
GERD	☐	☐

URINARY

Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urination	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐

BLOOD

Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐

OTHER

Radiation therapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐

Are you allergic or have you ever experienced any reaction to the following?

	YES	NO
Local anesthetics	☐	☐
Barbiturates (sleeping pills)	☐	☐
Penicillin (antibiotics)	☐	☐
Latex	☐	☐
Sulfa	☐	☐
Codeine	☐	☐
Iodine	☐	☐

Other _____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone (____) _____

Physician's Name _____

Physician's Phone (____) _____

To the best of my knowledge, all of the preceding answers are true and correct

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment

_____ _____

Signature Date

To Our Appreciated Patient,

Welcome and thank you for choosing Parma Ridge Family Dental. This year marks the beginning of many exciting changes. Our Vision is to create a warm, welcoming and family oriented environment that offers quality dental health care. Our professional staff strives to serve our patients with compassion, respect and first class dental care. Our team is committed to providing each patient with the appropriate treatment to ensure them a lifetime of excellent oral health. We do our utmost to optimize patient comfort, to be attentive to our patients needs and to maintain an atmosphere of open and friendly communication. It is our goal to create a practice built on lasting relationships with friends.

Therefore the following must be agreed upon by initialing:

1. No shows are not acceptable. Failure to keep a scheduled appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot keep an appointment (except in the case of an emergency) you are expected to call and speak with office staff 24 hours before your appointment. (Leaving a message is NOT considered 24 hour notice.) There is a $50.00 fee for each no-show appointment and is NOT covered by your insurance. _____

2. We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment. And it may be subject to our $50.00 No Show Fee.
_____

3. If you do miss an appointment we ask that you call to reschedule. It is critical to your to health to do so to avoid setbacks in your oral health. _____

4. **INSURANCE**: Treatment recommendations are based on your health NOT on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. Remember, insurance companies are not concerned about your health or well-being, we are. As a courtesy we will provide you with an estimate of benefits, and copays. This is ONLY AN ESTIMATE and at times can change, we are required to follow the explanation of benefits that your insurance company sends. **DENIED SERVICES ARE YOUR FULL RESPONSIBLITY.** Your benefits are between you and your insurance company, **NOT** between your insurance company and us. As a reminder, we cannot be responsible for what your insurance will or will not cover.
_____

5. **We strive to run a statement free office. In order to achieve this, we REQUIRE a portion of your out-of-pocket payment to secure your appointment time, the REMAINING out-of-pocket responsibilty is due the day treatment is started. Please speak to a team member if you have any questions regarding financial options**. _____

6. Emergencies: It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we will provide you with the next available emergency appointment. We will do our best to see you that same day.

In closing, it is our goal to create and exceptional experience every time you visit our office. Please feel free to discuss any issues that arise. No problem is too big or too small.

Yours in Health,

Dr. Rebecca Gecovich.

I have read and agree to the terms of the appreciated patient letter.

_____ _____

(Patient or Parent/Guardian Signature) (Date)

_____

(Print Patient Name)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

I give permission for Parma Ridge Family Dental to share information with:

1. _____ _____
_____

Name Relationship
Phone Number

2. _____ _____
_____

Name Relationship
Phone Number

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Noticeo f Privacy Practices, but acknowledgement could not be obtained because:

[] Individual refused to sign

[] Communication barriers prohibited obtaining the acknowledgement

[] An emergency situation prevented us from obtaining acknowledgement

[] Other (Please Specify)

_____
_____

_____
_____

_____
_____