MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____ Sex: ○ Male ○ Female

Are you under the care of a physician?
Physician Name: _____ Phone number (including area code): _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ○ Yes ○ No
If yes, explain: _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ○ Yes ○ No
If so, please list all: _____

Have you ever had any orthopedic total joint replacement? ○ Yes ○ No Date of replacement: _____

Do you use controlled substances (drugs)? ○ Yes ○ No

Do you use tobacco (smoking, snuff, chew, bidis)? ○ Yes ○ No

WOMEN ONLY - Are you:
Pregnant? ○ Yes ○ No If yes, number of weeks?_____ Nursing: ○ Yes ○ No
Taking birth control pills or hormonal replacement? ○ Yes ○ No

Allergies, are you allergic to or have you had any reaction to:

Local anesthetics: ○ Yes ○ No Iodine: ○ Yes ○ No Aspirin: ○ Yes ○ No Animals: ○ Yes ○ No
Hay fever/seasonal: ○ Yes ○ No Food: ○ Yes ○ No Sulfa Drugs: ○ Yes ○ No Metals: ○ Yes ○ No
Latex (rubber): ○ Yes ○ No Codeine or other narcotics: ○ Yes ○ No Barbiturates, sedatives, or sleeping pills: ○ Yes ○ No
Other: ○ Yes ○ No If other, please specify: _____

Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve ○ Yes ○ No	Congenital heart disease (CHD) ○ Yes ○ No	Angina ○ Yes ○ No
Cardiovascular Disease…….. ○ Yes ○ No	Severe headaches/migraines ○ Yes ○ No	Anemia ○ Yes ○ No
Blood Transfusion…… ○ Yes ○ No	Arteriosclerosis ○ Yes ○ No	Hemophilia ○ Yes ○ No
If yes, date of transfusion: _____	Arthritis ○ Yes ○ No	Asthma ○ Yes ○ No
Congestive Heart Failure ○ Yes ○ No	Damaged heart valves ○ Yes ○ No	AIDS or HIV ○ Yes ○ No
Heart Attack …… ○ Yes ○ No	Autoimmune disease ○ Yes ○ No	Heart murmur ○ Yes ○ No
Low blood pressure……..…. ○ Yes ○ No	Rheumatoid arthritis ○ Yes ○ No	Pacemaker ○ Yes ○ No
High blood pressure…….. ○ Yes ○ No	Mitral valve prolapse ○ Yes ○ No	Rheumatic fever ○ Yes ○ No
Rheumatic heart disease…..… ○ Yes ○ No	Sinus trouble ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Abnormal bleeding…….. ○ Yes ○ No	Chronic pain ○ Yes ○ No	Sleep disorder ○ Yes ○ No
Diabetes Type I or II…… ○ Yes ○ No	Eating disorder ○ Yes ○ No	G.E. Reflux/persistent heartburn ○ Yes ○ No
Mental health disorders…….. ○ Yes ○ No	Malnutrition ○ Yes ○ No	Gastrointestinal disease ○ Yes ○ No
Severe or rapid weight loss…… ○ Yes ○ No	Stroke ○ Yes ○ No	Fainting spells or seizures ○ Yes ○ No
Epilepsy…… ○ Yes ○ No	Glaucoma ○ Yes ○ No	Neurological disorders ○ Yes ○ No
Osteoporosis…… ○ Yes ○ No	Hepatitis, jaundice or liver disease ○ Yes ○ No	Sexually transmitted disease ○ Yes ○ No
Neurological disorders……..... ○ Yes ○ No	Cancer/Chemotherapy/Radiation Treatment ○ Yes ○ No	

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ○ Yes ○ No

Name of physician or dentist making recommendation (include phone number): _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ○ Yes ○ No

If yes, please explain: _____

_____

_____ _____
Signature of Patient/Legal Guardian **Date**

PATIENT REGISTRATION

Patient Information

First Name: _____ MI: _____ Last Name_____

Preferred Name: _____ Date of Birth: _____ ⚪ Male ⚪ Female

Patient Address:_____

City:_____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____ Ext: _____

E-mail: _____ Referral: _____

Primary Insurance Information

Policy Holder Name: _____ Date of Birth: _____

Social Security Number: _____ Relationship to patient: _____

Policy Holder Address: _____

City:_____ State: _____ Zip Code: _____

Employer: _____ Insurance Company: _____

Group Number:_____ Policy Holder ID: _____

Insurance Company Address: _____

City:_____ State: _____ Zip Code: _____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

City:_____ State: _____ Zip Code: _____

FINANCIAL POLICY

Thank you for selecting us as your personal dental care team. To promote a long-term mutually satisfying relationship, we would like to explain our office policies regarding treatment, insurance, appointments and fees. Please read this carefully and feel free to ask any questions or bring up any concerns you may have. Our friendly office staff is here to help you!

Treatment

Dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining health services. If your insurance company rejects a claim or refuses to pay for a service, it is not a reflection of how important a service is. We will however, always offer alternate treatment options that may better fit your health care budget.

Insurance

As a courtesy to you we will submit all insurance claims on your behalf and any follow-up processes that may be necessary. Our staff prides itself in helping our patients maximize their benefits. We strongly advise you, as our patient, to familiarize yourself with your dental coverage and benefits. You must remember, dental insurances are designed to offset the cost of your dental treatment.
Ultimately, the patient is fully responsible for the charges for the treatment rendered.
We make **NO GUARANTEE** OF THE ACTUAL PAYMENT BY YOUR INSURANCE COMPANY.
We accept Check, Cash, Money Order, Visa, MasterCard and Discover.

We offer interest free extended payment plans through Care Credit.

Please Note: Our office has a **48 hour cancellation policy**. Your appointment time is reserved especially for our patient to provide you with outstanding care. We strive to provide you with a two day courtesy reminder via email, text or call: however it is ultimately your responsibility to remember your appointment. There is a $50.00-$100.00 fee for missed or canceled appointments with less than 48 hours notice. *For sedation cases or appointment times that require 2 or more hours we may request a pre-prepayment to reserve the allotted time.

To avoid increasing fees to our patients, any account balance over 30 days will accrue finance fees. All accounts over 90 days will be notified in writing of their account being transferred to a collection agency. Additional fees will then be assessed and billed by the collection agency. Returned check will result in a $45.00 charge to your account.

Photo Consent

I hereby grant permission to Dr. Taormina to use my photograph(s) and any testimonial I give regarding the dental care I receive from any such office, in any marketing consents, advertising or teaching materials used to market or advertise his/her dental practices including use on Dr. Taormina's website. I acknowledge discretion. I also acknowledge that the doctor may choose not to use my photograph(s) and/or testimonial at this time, but may do so at his own discretion at a later date. I also understand that once my image is posted on Serenity Advanced Dentistry's website, the image can be downloaded by any computer user, which is beyond the control of the doctor. I will hold him/her and any of his affiliated offices harmless from any such use or download. I hereby freely and voluntarily consent to the use of my photograph(s) and testimonial as stated above until I revoke this consent in writing.

☐ **Please check this box if you would not like your photograph(s) and/or testimonial used in any way.**

SIGNATURE: _____ DATE: _____

To revoke this consent in writing, please contact:
Dr Gregg Taormina
Serenity Advanced Dentistry
6250 Route 209
Stroudsburg, PA 18360

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

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

Date: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any caretakers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The undersigned acknowledges receipt of a copy, if desired, of the current 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 PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority