MEDICAL HISTORY FORM

Physical Name: Phone number (including area code):	Patient Name:	Date of Birth:	Sex: Male Female
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 WOMEN ONLY - Are you: Pregnant? Yes No Tell 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 I of line: Yes No Sulfa Drugs: Yes No Metals: Yes No Latex (nubber): Yes No Codeine or other nancelosts: Yes No Barbitrates, sedatives, or sleeping pills: Yes No Latex (nubber): Yes No I of other, please specify: Please indicate if you have had or not had any of the following: Artificial (prosthetic) heart valve Yes No Severe headsches/migraines Yes No Anemia Yes No Blood Transfusion. Yes No Anterioscierosis Yes No Hemphilia Yes No Congestive Heart Failure Yes No Damaged heart valves Yes No Heart mumur Yes No Low blood pressure. Yes No Autoimmune disease Yes No Heart mumur Yes No Low blood pressure. Yes No Rheumatich darthitis Yes No Rheumatic fever Yes No No Abnormal bleeding. Yes No Bairus trouble Yes No Sinus trouble Yes No Gastroites the arbitrates and the rest of the prolapse Yes No Finus Heart mumur Yes No Abnormal bleeding. Yes No Bairus trouble Yes No Gastroites Yes No Rheumatic fever Yes No Sinus trouble Yes No Tell yes, glaced of transfusion. Yes No Sinus trouble Yes No Gastroites of Yes No Rheumatic fever Yes No Sinus trouble Yes No Tell yes, glaced of Yes No Severe or rapid weight loss. Yes No Maintri valve prolapse Yes No Fainting spells or seizures Yes No Replaceding. Yes No Allormore Prolapse Yes No Fainting spells or seizures Yes No Replaced Group Yes No Repetitis, jaundice or liver disease. Yes No Allorondores No Permedication Has a physician or previous dentist recommended that you take antib	Are you under the care of a physician? Physician Name:	Phone number (include	ding area code):
Have you ever had any orthopedic total joint replacement? Yes No Date of replacement: Do you use controlled substances (drugs)? Yes No WoMEN ONLY - Are you: Pregnant? Yes No If yes, number of weeks? Nursing: Yes No Allergies, are you allergic to or have you had any reaction to: Local anestheties: Yes No Dodine: Yes No Sulfa Drugs: Yes No Metals: Yes No Hay fever/seasonal: Yes No Food: Yes No Sulfa Drugs: Yes No Metals: Yes No Latex (nubber): Yes No Codeine or other narcotics: Yes No Barbiturates, sedatives, or sleeping pills: Yes No Cardiovascular Disease. No Severe headaches/migraines Yes No Angina Yes No If yes, date of transfusion: Yes No Damaged heart valve Yes No Anthrilts Yes No Angina Yes No Heart Attack. Yes No Autoimmune disease Yes No Heart murmur Yes No Heart Attack. Yes No Repeated that you take antibiotics prior to your dental treatment? Yes No Mental health disorders. Yes No Gastrointedial disease Yes No Repetition or Pacemaker Yes No Angina Yes No Heart attack. Yes No Repetition of Repetition of Reparation or Pacemaker Yes No Repetition of Reputation or Pacemaker Yes No Repetition of Reputation or Pacemaker Yes No Reputation Pacemaker Yes No Rep			
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?			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 Sulfa Drugs: Yes No Animals: Yes No Hay fever/seasonal: Yes No Food: Yes No Sulfa Drugs: Yes No Metals: 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 Severe headaches/migraines Yes No Anemia Yes No Blood Transfusion. Yes No Anemia Yes No Anemia Yes No Congestive Heart Failure Yes No Autoimmune disease Yes No Autoimmune Yes No Anemia Yes No Congestive Heart Failure Yes No Autoimmune disease Yes No Heart unimum Yes No Low blood pressure. Yes No Autoimmune disease Yes No Reumatic fever Yes No Remember Yes No Gastrointestinal disease Yes No Gastrointestinal disease Yes No Gastrointestinal disease Yes No Gastrointestinal disease Yes No Mental file of Processure Yes No Gastrointestinal disease Yes No Gastrointestinal disease Yes No Gastrointestinal disease Yes No Remember Yes No Gastrointestinal disease Yes No Gastrointestinal disease Yes No Gastrointestinal disease Yes No Remove Severe or rapid weight loss. Yes No Gastrointestinal disease Yes No Mental health disorders. Yes No Gastrointestinal disease Yes No Mental health disorders. Yes No Gastrointestinal disease Yes No Gesere or rapid weight loss. Yes No Hepatitis, jaundice or liver disease Yes No Sexually transmitted disease Yes No Neurological disorders Yes No Neurological	Have you ever had any orthopedic total jo	int replacement? Yes No Date of replacement	acement:
WOMEN ONLY - Are you: Pregnant? Yes No If yes, number of weeks? No Nursing: Yes No Alimais: Yes No Aliergies, are you allergic to or have you had any reaction to: Local anesthetics: Yes No lodine: Yes No Aspirin: Yes No Animals: Yes No Hay fever/seasonal: Yes No Food: Yes No Sulfa Drugs: Yes No Metals: Yes No Other: Yes No Codiene or other narroctics: Yes No Barbiturates, sedatives, or sleeping pills: Yes No Other: Yes No Indine: Yes No Codiene or other narroctics: Yes No Barbiturates, sedatives, or sleeping pills: Yes No Other: Yes No Indine: Yes No Cordio-Read No Codiene or other narroctics: Yes No Barbiturates, sedatives, or sleeping pills: Yes No Other: Yes No Indine: Yes No Cardiovascular Disease. Yes No Congenital heart disease (CHD) Yes No Anemia Yes No Cardiovascular Disease. Yes No Arteriosclerosis Yes No Anemia Yes No Anemia Yes No Arteriosclerosis Yes No Anemia Yes No Congestive Heart Failure Yes No Arteriosclerosis Yes No Anemia Yes No Congestive Heart Failure Yes No Autoimmune disease Yes No Heart Matack. Yes No Abnormal bleeding. Yes No Rheumatici dearth Yes No Rheumatici dearth Yes No Rheumatici dearth Yes No Rheumatic heart disease. Yes No Mitral valve prolapse Yes No Rheumatic fever Yes No Abnormal bleeding. Yes No Eating disorder Yes No Gastrointestinal disease Yes No Mental theart disease. Yes No Gastrointestinal disease Yes No Nemental health disorders. Yes No Hepatitis, jaundice or liver disease Yes No Sexually transmitted disease Yes No Neurological disorders	Do you use controlled substances (drugs)	? Yes No	
Pregnant? Yes No If yes, number of weeks? Nor Sakip th control pills or hormonal replacement? Yes No Norsing: Yes No Aspirin: Yes No Animals: Yes No Hay fever/seasonal: Yes No Iodine: Yes No Sulfa Drugs: Yes No Metals: Yes No Other: Yes No Codeine or other narcotics: Yes No Barbiturates, sedatives, or sleeping pills: Yes No Other: Yes No Codeine or other narcotics: Yes No Barbiturates, sedatives, or sleeping pills: Yes No Other: 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 Arteriosclerosis Yes No Hemophilia Yes No Isource of Arthritis Yes No Asthma Yes No Congestive Heart Failure Yes No Damaged heart valves Yes No AlDS or HIV Yes No Heart Attack. Yes No Autoimmune disease Yes No Heart Attack. Yes No Remanded arthritis Yes No Remanded Pressure. Yes No Remanded Press No Remanded Pressure. Yes N	Do you use tobacco (smoking, snuff, chev	v, bidis)? Yes No	
Local anesthetics: Yes No lodine: Yes No Sayirin: Yes No Animals: Yes No Hay fever/seasonal: 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 Arteriosclerosis Yes No Asthma Yes No Congestive Heart Failure Yes No Damaged heart valves Yes No Autoimmune disease Yes No AlDS or Heart murmur Yes No Heart Attack Yes No Autoimmune disease Yes No Acteriosclerosis Yes No Anemia Yes No Congestive Heart Failure Yes No Autoimmune disease Yes No AlDS or Heart murmur Yes No Heart Millor Pressure. Yes No Mitral valve prolapse Yes No Reumatic heart disease. Yes No Beader Yes No Reumatic heart disease. Yes No Gastrointestinal disease Yes No Beader Yes No Diabetes Type I or II. Yes No Gastrointestinal disease Yes No Gastrointestinal disease Yes No Repair Yes No Repair Yes No Gastrointestinal disease Yes No Repair Yes No Repair Yes No Gastrointestinal disease Yes No Repair Yes No Repair Yes No Gastrointestinal disease Yes No Repair Yes No Repair Yes No Gastrointestinal disease Yes No Repair			Yes No
Artificial (prosthetic) heart valve Yes No Congenital heart disease (CHD) Yes No Angina Yes No Cardiovascular Disease	Local anesthetics: Yes No Hay fever/seasonal: Yes No Latex (rubber): Yes No Code	lodine: Yes No Aspirin Food: Yes No Sulfa Drugs ine or other narcotics: Yes No Barb	s: Yes No Metals: Yes No iturates, sedatives, or sleeping pills: Yes No
Cardiovascular Disease	Please indicate if you have had or i	not had any of the following:	
Blood Transfusion	Artificial (prosthetic) heart valve Yes	No Congenital heart disease (CHD) Yes	No Angina Yes No
If yes, date of transfusion: ArthritisYesNo AsthmaYesNo	Cardiovascular DiseaseYes	No Severe headaches/migraines Yes	No Anemia Yes No
Congestive Heart Failure	Blood TransfusionYes	No Arteriosclerosis Yes	No Hemophilia Yes No
Heart Attack	If yes, date of transfusion:	Arthritis Yes	No Asthma Yes No
Low blood pressure	Congestive Heart Failure Yes	No Damaged heart valves Yes	No AIDS or HIV Yes No
High blood pressure	Heart AttackYes	No Autoimmune disease Yes	No Heart murmur Yes No
Rheumatic heart disease	Low blood pressureYes	No Rheumatoid arthritis Yes	No Pacemaker Yes No
Abnormal bleeding	High blood pressureYes	No Mitral valve prolapse Yes	No Rheumatic fever Yes No
Diabetes Type I or II	Rheumatic heart disease Yes	No Sinus trouble Yes	No Tuberculosis Yes No
Diabetes Type I or II	Abnormal bleedingYes	No Chronic pain Yes	No Sleep disorder Yes No
Severe or rapid weight loss			No G.E. Reflux/persistent heartburn Yes No
Severe or rapid weight loss	Mental health disordersYes	No Malnutrition Yes	No Gastrointestinal disease Yes No
Epilepsy	Severe or rapid weight loss Yes	No Stroke Yes	No Fainting spells or seizures 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	EpilepsyYes	No Glaucoma Yes	No Neurological disorders 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	OsteoporosisYes	No Hepatitis, jaundice or liver disease Yes	No Sexually transmitted disease Yes No
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	Neurological disordersYes	No Cancer/Chemotherapy/Radiation Treatment	Yes No
Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No		ist recommended that you take antibiotics prior to yo	our dental treatment? Yes No
	Name of physician or dentist ma	king recommendation (include phone number):	
If yes, please explain:	Do you have any disease, condition, or pr	oblem not listed above that you think I should know a	about? Yes No
	If yes, please explain:		

Date

Signature of Patient/Legal Guardian

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: ____ 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.

\square Please check this box if you would not like your photog	raph(s) and/or testimonial used in any way.
SIGNATURE:	DATE:

Serenity Advanced Dentistr 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:	
	CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: nd any caretakers who can have access to this patient's records):
Name:	Relationship:
Name:	Relationship:
this healthcare facility. A copy of this signed MY SIGNATURE WILL ALSO SERVE AS A	copy, if desired, of the current effective Notice of Privacy Practices for , dated document shall be as effective as the original. PROTECTED HEALTH INFORMATION DOCUMENT RELEASE ADIOGRAPHS BE SENT TO OTHER ATTENDING
Please <u>print</u> your name	Please <u>sign</u> your name
Legal Representative	Description of Authority