

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Gender: _____ Family Status: _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
 Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S
 Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____
 Name of person or office referring you to our practice: _____

Email Address: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____ Phone _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____
Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insurance Plan Name and Address: «Plns Name»

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____
Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insurance Plan Name and Address: «Slms Name»

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

Dental Insurance:

Your dental insurance policy is a contract between you and your insurance company.

Dr. Masciadri is NOT a network provider with ANY dental insurance. It is your responsibility to know and understand your policy and dental coverage.

As a courtesy to our patients, we will file your dental claims to your insurance; however, we **require your estimated co-payment at the time of service.**

Dental insurances may have different standards for "*usual and customary*" fees, or they may pay on a defined benefits schedule. In most cases, reimbursement provided by the insurance carrier won't completely cover your costs. In these cases you are responsible to pay the difference.

I have read and understand the dental insurance policy.

Print Name

Date

Signature

Date

Rosanna U. Masciadri, D.M.D., P.C

1175 Oglethorpe Avenue

Athens, Georgia 30606

Tel # (706) 227-2502

Email Address dental@drrosannamasciadri.com

Patient Consent of Protected Information (PHI)

Date: _____

Patient's Name: _____ Date of Birth: _____

Please list the person(s) we may discuss your dental/medical information with:

Name _____ Relationship _____

Phone# _____

Ok to Discuss: () Appointments () Treatment Plan () Test Results () Billing Information

Name _____ Relationship _____

Phone# _____

Ok to Discuss: () Appointments () Treatment Plan () Test Results () Billing Information

Name _____ Relationship _____

Phone# _____

Ok to Discuss: () Appointments () Treatment Plan () Test Results () Billing Information

Patient Signature _____ Date _____

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

This worksheet is designed to help you identify priorities for your first meeting with us. Please feel free to use it in any way that is helpful.

- What prompted you to pick up the phone and call?
- What do you hope to accomplish from your first visit with us?
- Please think about your previous dental experiences. What things have you experienced before that you would like to find in our office?
- What experiences would you like to avoid or eliminate?
- What are the main problems, issues, or challenges that you would like us to help you with?
- What time, economic, or other considerations would you like for us to keep in mind?
- What should we know about you in order to work most effectively with you?

Rosanna U. Masciadri, D.M.D., P.C.
1175 Oglethorpe Avenue
Athens, Georgia 30606
Tel: (706)227-2502
Fax: (706)227-0207

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient's Name _____

Patient's Birth Date _____ Patient SSN _____

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of TREATMENT, various activities associated with payment, electronic insurance transmittal, email and healthcare operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and healthcare operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have the right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our PRIVACY OFFICER. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent after you have signed it.

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, electronic insurance transmittal, payment activities and health care operations.

Patient's Signature or Signature of Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

Our Privacy Officer can be contacted as Follows:

Name of Privacy Officer: Frances V. Fincher

Address: 1175 Oglethorpe Avenue Athens, Georgia

Phone: (706)-227-2502 Fax: (706) 227-0207 Email: dental@drrosannamasciadri.com