OFFICE USE ONLY: Acct. # _____

Patient Information

Please Print

Circle One: Dr/Mr/Mrs/Ms/Miss

First: _____ Middle: _____ Last: _____ Jr/Sr: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email Address: _____ May we contact you by email? (circle) **Yes No**

Patient Social Security Number: _____ Patient Date of Birth: _____ Sex: (circle) **M F**

Emergency Contact: _____ Phone: _____

Preferred Pharmacy _____

How did you hear about us?

☐Newspaper ☐Radio ☐TV ☐Internet ☐Referral ☐Other: _____

Insurance Information

Do you have Dental Insurance? (circle) **Yes No** Do you have Secondary Dental Insurance? (circle) **Yes No**

Primary Insured		**Secondary Insured**	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber	☐Self ☐Spouse ☐Child ☐Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
Please present your insurance card to our patient services representative to be photocopied			

Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____

Relationship to the Patient: _____

I give authorization to disclose the following information:

- ☐ All treatment information
- ☐ Information specifically related to these treatment dates

Starting Date: _____ End Date: _____

I understand that I may withdraw or revoke my permission at any time.

Signature of Patient (or Patient Representative) _____ Date: _____

Printed Name of Patient (or Patient Representative) _____

PATIENT'S NAME _____ _____ _____ _____

last first in tial nickname date of birth

DENTAL HISTORY -CIRCLE THE APPROPRIATE ANSWER COMMENTS

1. Is this your first visit to our office? ..... YES NO
2. Purpose of initial visit.. Check up __ cleaning ___ tooth ache ____
   explain _____
3. How long since the last visit to the dentist ? _____
4. Previous dentist's name _____
5. Were any X - rays taken during your previous visit to the dentist.... YES NO
6. How often do you brush your teeth ? ___ Upon arising
   ___ After meals ___ Before going to bed
7. Do you floss your teeth ? ..... YES NO
8. Does your drinking water contain Fluoride ? ..... YES NO
9. Do you (your child) receive Fluoride ? ____ community water
   ___ fluoride drops of tabs ___ fluoride rinse or gel
10. Have any teeth been removed because of cavities ? ..... YES NO
11. Have any teeth been removed because of gum problems ? ..... YES NO
12. Have your wisdom teeth been removed ? ..... YES NO
13. Have you had braces ? ..... YES NO
14. Have there been any injuries to your teeth : falls, blows, fractures? YES NO
15. Describe injury _____
16. Have you received local anesthetic for dental treatment ? ..... YES NO
17. Have you had any difficulty with extractions ? ..... YES NO
18. Describe difficulty _____
19. Have any missing teeth been replaced ? ..... YES NO
20. Describe replacement _____
21. Do you clench or grind your teeth ? ..... YES NO
22. Does your jaw click or pop ? ..... YES NO
23. Do you have frequent head aches ? ..... YES NO
24. Do the muscles of your face or neck hurt ? ..... YES NO
25. Are any of your teeth sensitive to: __ hot __ cold __ sweets __ pressure
26. Do your gums bleed, hurt ? ..... YES NO
27. Do you have any loose teeth ? ..... YES NO
28. Do you feel that your breath is offensive ? ..... YES NO
29. Are you unhappy with the appearance of your teeth ?..... YES NO
    Would you like to have whiter teeth ? ..... YES NO
    Would you like to change the shape of your teeth ? ..... YES NO
30. How do you feel about your teeth in general ? _____
    _____
31. Is there anything about dentistry that you strongly dislike ? _____
    _____
32. Describe the most important outcome for your dental treatment . _____
    _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT' S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTAL HEALTH

AJP 2000

PATIENT'S NAME _____ _____ _____

last first initial date of birth

MEDICAL HISTORY - PLEASE CIRCLE THE APPROPRIATE ANSWER.

1. Physician's Name _____
   Address _____
2. Are you under a physician's care ? ..... YES NO
   Since when _____ Why _____
3. When was your last physician exam ? _____
4. Are you taking any medication or health related substances ? ..... YES NO
   List _____
   _____
5. Are you allergic to any medications or substances ? ..... YES NO
6. Do you have any other allergies ? ..... YES NO
7. Do you have any problems with penicillin, antibiotics, anesthetics, or any medications ? ..... YES NO
8. Are you sensitive to any metals or latex ? ..... YES NO
9. Are you pregnant or suspect you may be ? ..... YES NO
10. Do you take any birth control medications ? ..... YES NO
11. Have you ever been treated for heart disease ? ..... YES NO
12. Do you have a pacemaker ? ..... YES NO
13. Do you have an artificial heart valve ? ..... YES NO
14. Do you have any heart murmurs ? ..... YES NO
15. Have you ever had rheumatic fever ? ..... YES NO
16. Do you have high blood pressure ? ..... YES NO
17. Do you have low blood pressure ? ..... YES NO
18. Do you have any blood disorders, such as anemia, leukemia, ITP ..... YES NO
19. Do you bleed excessively after being cut or injured ? ..... YES NO
20. Do you have a blood sugar problem or diabetes ? ..... YES NO
21. Have you ever tested HIV positive ? ..... YES NO
22. Do you have AIDS ? ..... YES NO
23. Do you have or have you had a venereal disease ? ..... YES NO
24. Have you had any tumors, chemotherapy, or radiation therapy ? ..... YES NO
25. Do you have inflammatory disorders as arthritis, lupus, etc. ? ..... YES NO
26. Do you have any artificial joints or prosthesis, or shunts ? ..... YES NO
27. Do you have asthma ? ..... YES NO
28. Have you had T. B. ? ..... YES NO
29. Do you smoke or use tobacco ? ..... YES NO
30. Do you get short of breath easily ? ..... YES NO
31. Do you have epilepsy or seizure disorders ? ..... YES NO
32. Do you have any liver problems ? ..... YES NO
33. Do you have any kidney problems ? ..... YES NO
34. Do you have any stomach problems ? ..... YES NO
35. Do you habitually consume alcoholic beverages ? ..... YES NO
36. Do you habitually use non prescription substances ? ..... YES NO
37. Do you have any psychiatric disorders ? ..... YES NO
38. Have you had a serious illness or major surgery ? ..... YES NO
    If so, explain _____
39. Do you have any disease, condition, or problem not listed ? ..... YES NO
    If so, explain _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT / GUARDIAN SIGNATURE _____ DATE _____

MEDICAL HEALTH

AJP 2000

Andrew Ponichtera, D.M.D., M.S.

Prosthodontist

OFFICE POLICY AND CONSENT FORM

INSURANCE AND PAYMENT POLICIES

- Fees for services rendered will be requested at the time of your visit. This includes those who do not carry dental insurance and the Co-Pay and/or deductible for those that do. For treatment involving fees above $500.00, special financial arrangements can be made.

- For patients with dental insurance:
  - We will file your claim for you at no charge, however, we ask that your deductibles and your estimated portions (20-60%) be paid as services are rendered. Although we gladly file insurance claims, any and all account balances are ultimately your responsibility.
  - All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment or there is supplemental/secondary coverage and the primary carrier paid the full amount.
  - We are participating providers for the following dental companies: Anthem (except the Federal program), Cigna PPO, MetLife, Delta Dental (all states), and BeneCare through ConnectiCare. This means we are obligated to accept their fees for services. For any other dental insurance carrier, the out of pocket costs to you may be higher for services rendered. *It is the responsibility of the patient to know and understand your benefits. We will provide information when possible, but ultimate responsibility lies with you. This includes maximums, deductibles, copays and remaining balances.*

- Collections: Regardless of Dental Insurance or self pay, should any outstanding balance remain unpaid longer than 90 days without arrangement with the office, patients will be forwarded to Collections and responsible for any collection fees, court costs, returned check fees and reasonable attorney fees associated with collecting any balance due Dr. Andrew Ponichtera.

- For your convenience we accept VISA, MasterCard, Discover, American Express and Care Credit as well as checks and cash.

CONSENT:

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform diagnostic and treatment procedures deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Signature:_____ Date: _____

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ajponichteradmdmss@comcast.net