DR. D'AMICO'S DENTAL CENTER

Dr. Elio C.J. D'Amico D.D.S.
4325 Tamiami Trail North
Naples, FL 34103
Phone: 239-234-5284
Fax: 239-234-5287

Patient Registration

Chart ID_________

Patient information

First name: ____________________ Last Name: ______________________ Middle initial: ____ Preferred Name________________

Address: ________________________________ City: _______________________ State________________ Zip Code____________

Home Phone: ______________________ Work Phone: ____________________

Cellular: ___________________________ ☐ I would like to receive correspondences via text messaging.

Birth Date: _________________ Age: _______ Social Sec.#: __________________ Driver's License__________________________

Email: ____ ☐ I would like to receive correspondences via e-email

Sex: ☐ Male ☐ Female Martial Status: ☐ Married ☐ Single ☐ Divorced ☐ Seperated ☐ Widowed

Insurance Information

Insurance company____________________________
Insurance Phone#:_____________________________
ID number:___________________________
Group#:__________________ Employer:________________
Subsciber Information (person whom policy is under if not patient).
Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
First Name:______________________________
Last Name:______________________________
Social security number:______________________
Date of Birth:_________________________
Address:________________________________
City:__________________ Zip Code___________

Secondary Insurance Information

Insurance company____________________________
Insurance Phone#:_____________________________________
ID number:___________________________
Group #:______________ Employer: __________________
Subsciber Information (person whom policy is under if not patient).
Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
First Name:______________________________
Last Name:______________________________
Social security number:______________________
Date of Birth:_______________________
Address:____
City:__________________ Zip Code___________

Responsible party (if other than patient)

First name: ____________________ Last Name: ______________________ Middle initial: ____ Preferred Name________________
Address: ________________________________ City: _______________________ State: ____________ Zip Code: ______________
Home Phone: ______________________ Work Phone: ____________________ Cellular: ____________________

Emergency Contact:
Name: ____ Phone number: ____

How did you hear about our office? ☐ TV ☐ Radio ☐ Valpak ☐ Dentist:____________ ____ ☐ Family/Friend:_________________

☐ Walk in ☐ Other:____

Patient Signature(or responsibe party)______________________________________ **Date:**_____________________________________

MEDICAL HISTORY

PATIENT NAME ______________________ **Birth Date** ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ______

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯Yes ◯No	Cortisone Medicine	◯Yes ◯No	Hemophilia	◯Yes ◯No	Radiation Treatments	◯Yes ◯No
Alzheimer's Disease	◯Yes ◯No	Diabetes	◯Yes ◯No	Hepatitis A	◯Yes ◯No	Recent Weight Loss	◯Yes ◯No
Anaphylaxis	◯Yes ◯No	Drug Addiction	◯Yes ◯No	Hepatitis B or C	◯Yes ◯No	Renal Dialysis	◯Yes ◯No
Anemia	◯Yes ◯No	Easily Winded	◯Yes ◯No	Herpes	◯Yes ◯No	Rheumatic Fever	◯Yes ◯No
Angina	◯Yes ◯No	Emphysema	◯Yes ◯No	High Blood Pressure	◯Yes ◯No	Rheumatism	◯Yes ◯No
Arthritis/Gout	◯Yes ◯No	Epilepsy or Seizures	◯Yes ◯No	High Cholesterol	◯Yes ◯No	Scarlet Fever	◯Yes ◯No
Artificial Heart Valve	◯Yes ◯No	Excessive Bleeding	◯Yes ◯No	Hives or Rash	◯Yes ◯No	Shingles	◯Yes ◯No
Artificial Joint	◯Yes ◯No	Excessive Thirst	◯Yes ◯No	Hypoglycemia	◯Yes ◯No	Sickle Cell Disease	◯Yes ◯No
Asthma	◯Yes ◯No	Fainting Spells/Dizziness	◯Yes ◯No	Irregular Heartbeat	◯Yes ◯No	Sinus Trouble	◯Yes ◯No
Blood Disease	◯Yes ◯No	Frequent Cough	◯Yes ◯No	Kidney Problems	◯Yes ◯No	Spina Bifida	◯Yes ◯No
Blood Transfusion	◯Yes ◯No	Frequent Diarrhea	◯Yes ◯No	Leukemia	◯Yes ◯No	Stomach/Intestinal Disease	◯Yes ◯No
Breathing Problem	◯Yes ◯No	Frequent Headaches	◯Yes ◯No	Liver Disease	◯Yes ◯No	Stroke	◯Yes ◯No
Bruise Easily	◯Yes ◯No	Genital Herpes	◯Yes ◯No	Low Blood Pressure	◯Yes ◯No	Swelling of Limbs	◯Yes ◯No
Cancer	◯Yes ◯No	Glaucoma	◯Yes ◯No	Lung Disease	◯Yes ◯No	Thyroid Disease	◯Yes ◯No
Chemotherapy	◯Yes ◯No	Hay Fever	◯Yes ◯No	Mitral Valve Prolapse	◯Yes ◯No	Tonsillitis	◯Yes ◯No
Chest Pains	◯Yes ◯No	Heart Attack/Failure	◯Yes ◯No	Osteoporosis	◯Yes ◯No	Tuberculosis	◯Yes ◯No
Cold Sores/Fever Blisters	◯Yes ◯No	Heart Murmur	◯Yes ◯No	Pain in Jaw Joints	◯Yes ◯No	Tumors or Growths	◯Yes ◯No
Congenital Heart Disorder	◯Yes ◯No	Heart Pacemaker	◯Yes ◯No	Parathyroid Disease	◯Yes ◯No	Ulcers	◯Yes ◯No
Convulsions	◯Yes ◯No	Heart Trouble/Disease	◯Yes ◯No	Psychiatric Care	◯Yes ◯No	Venereal Disease	◯Yes ◯No
						Yellow Jaundice	◯Yes ◯No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______

Comments: ______

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ______

Reviewed by doctor: ______________________ Date: ______

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Privacy Practice Acknowledgement

I have received the notice of privacy practices and I have been provided an opportunity to review it.

Signature________________________________ **Date**____________________

You may speak to the following individuals on my behalf regarding any and all treatment, payment and financial concerns I may have:

Name___________________________ **Relationship to patient:** ___________________

Name___________________________ **Relationship to patient:** ___________________

Name___________________________ **Relationship to patient:** ___________________

Patient name_____________________________ **Date of Birth** ___________

Signature________________________________ **Date**_________________

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FINANCIAL POLICY

We are committed to provide you with the best possible care and welcome you to our office. If you have insurance, we are glad to help you receive your maximum allowance benefits. In order to achieve these goals, we need your understanding of our payment policy. We thank you for taking the time to read and understand the policy below.

- ALL NEW PATIENTS MUST COMPLETE OUR PATIENT INFORMATION FORMS BEFORE SEEING THE DOCTOR. PLEASE PROVIDE YOUR DRIVER'S LISCENCE AND YOUR INSURANCE CARD TO THE FRONT DESK FOR SCANNING IN YOUR CHART.
- PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPAINED BY A PARENT OR GUARDIAN. THE PARENT OR GUARDIAN IS RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.
- ANY ACCOUNT 90 DAYS PAST DUE WILL BE TURNED OVER TO OUR COLLECTION AGENCY AND WILL BE RESPONSIBLE FOR ALL COST OF COLLECTION IN ADDITION TO ANY UNPAID CHARGES. I AGREE TO PAY ALL COST OF THE COLLECTION, INCLUDING ATTORNEY FEES. THE COLLECTION FEE IS 40% OF THE UNPAID BALANCE.
- WE DO UNDERSTAND THAT EMERGENCIES OCCUR. WE KINDLY REQUEST 48 HOURS TO RESCHEDULE APPOINTMENTS. TO AVOID A **BROKEN APPOINTMENT FEE OF $62.00**, PLEASE CALL THE OFFICE 2 DAYS PRIOR TO AN APPOINTMENT.

Non-Insured Patients

Payment is due at the time services are rendered. For your convenience, payment can be made by **Cash, MasterCard, Visa, American Express, Discover, Care Credit, and Lending Club.**

If you are having treatment extending over a period of time, we expect payment prior or the same day of your appointment. If necessary, Financing is available through Care Credit or Lending Club.

Insured Patients

"As health care providers, our relationship is with you, not your insurance company."
It is your responsibility to pay any deductible amount or co-pay, unmet deductible for non-covered service at the time of each visit. As with any other insurance plans, if your insurance carrier has not paid your account within 90 days, the balance will automatically become due by you. Any resubmissions of insurance claims and appeals will be the patient's responsibility.

- Your insurance is a contract between you, the insurance company, and your employer. We are not a party to that contract. The filing of insurance claims is a courtesy that we extend.
- Not all services are a covered benefit in all contracts.
- Our estimate of insurance coverage is only an estimate based on the information available to us.

I HAVE READ AND UNDERSTOOD MY FINANCIAL RESPONSABILITIES.

Signature: ______________________________ **Date:** ____________________

Parent, If Minor: __________________________ **Date:** ____________________

✓ **Please Check If You Are Interested In Our Financing Options** _____ **Yes** _____ **No**