ruocco dental
COSMETIC & RESTORATIVE DENTISTRY

Medical History

Patient Name:_____ Today's Date: _____

Patient Date of Birth: _____ ☐ Male ☐ Female

Physician Name: _____ Physician Phone:_____

Previous Dentist:_____ Dentist Phone:_____

Approximate Date of Last Dental Visit: _____

Main Reason for Today's Visit:_____

Is there anything you would like to change about your smile?_____

If female please answer the following:

Y	N	
☐	☐	Are you taking birth control pills?
☐	☐	Are you pregnant? If Yes, # of weeks _____
☐	☐	Are you nursing?

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?
☐	☐	Are you under a physician's care?
☐	☐	Have you ever been told to premedicate with antibiotics prior to dental treatment?

Do you have, or have you ever had:

Y	N	Conditions
☐	☐	Abormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Bone Meds - Bisphosphonates
☐	☐	Cancer - Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Venereal Disease
☐	☐	Well Water
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____
_____
_____

Any other disease, conditions, or problems our office should know about? _____

_____

Medications currently taking: _____

_____

SIGNATURE: _____ DATE: _____

8418 New Town Rd. • Waxhaw, NC 28173
704.843.2880 • info@Ruoccodental.com

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Patient Information

Patient Name _____ Date _____

Address _____

City and State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

E-mail _____

Patient SS# _____ Date of Birth _____

Patient's Employer _____

Name of Spouse or Parent (if patient is a minor) _____

Address (if different from above) _____ SS# _____

City and State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Spouse or Parent's employer name _____

In case of emergency, who shall we notify? _____

Relationship? _____ Phone _____

How did you hear about our office? _____

Person responsible for payment of this account _____

***** Adult that brings in a minor child is responsible for payment on the day of service.**

TERMS AND CONDITIONS

In the event of a broken appointment, or a cancelled appointment with less than 2 business days notice, a fee may be applied to your account.

I understand payment or co-payment (insured patients) is due and payable in full at each appointment. In the event that this account becomes past due, the doctors, their assigns, or lawful agents may immediately consider the account in default and pursue collections procedures. If my account is past due I agree to pay 1.5% interest per month (15% annum) on unpaid balance from the date due, in addition to collection costs. Collection costs may include, but are not limited to court filing fees, service or processing costs and reasonable attorney fees of 30% of unpaid principle, or $50.00, whichever is greater. Any returned checks will be charged a processing fee of $25.00. I grant my permission to you or your assigns to telephone me at home or work to discuss matters related to this form.

Signature _____ Date _____

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Dental Insurance

Name of Insured _____

Insured Date of Birth _____ Relationship to Patient _____

Insurance Co. _____ Insured SS# _____

Insurance Address _____ Insured ID # _____

_____ Group # _____

Insurance Telephone _____ Plan # _____

Employer Name _____

Address _____

INSURANCE POLICIES

Our professional treatment is rendered to you, not your insurance company. You are responsible to us for the obligation of payment of treatment. Please understand that your insurance policy is a contract between you and your insurance company. Any problems of non-payment or delay of payment are your responsibility. Remember that dental benefits were never meant to determine your dental care; they are to assist you in the payment of your treatment choice.

Your are responsible for portions not covered by your policy on the day of service.

Any insurance balance over 60 days old is considered delinquent and is your responsibility to pay.

Please remember that we are not responsible for determining what your particular benefits are. Most policies cover what they consider "usual and customary" fee. However, the insurance company establishes these fees to meet their needs, and they are not always the same fees that may be charged in this office.

We will do our best to see that you receive the maximum benefit of your insurance. However, ultimate responsibility for payment is yours, and financial arrangements must be defined before dental treatment begins.

ASSIGNMENT OF BENEFITS
I authorize payment of dental benefits to the named provider for professional services rendered.

Signed: _____

Date: _____

RELEASE OF INFORMATION
I authorize the release of any dental information necessary to process this claim.

Signed: _____

Date: _____

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HIPAA

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

☐ An emergency existed and signature was not possible at the time.

☐ The individual refused to sign.

☐ A copy was mailed with a request for a signature by return mail.

☐ Unable to communicate with the patient for the following reason:

_____

☐ Other: _____

_____

Prepared By _____

Signature _____

Date _____

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Ruocco Dental
Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Ruocco Dental is authorized to release protected health information about the above named patient in the following manner and to persons listed.

May we leave you a voice mail about appointment reminders?	**YES**	**NO**
May we leave you a voicemail about financial information?	**YES**	**NO**
May we leave you a voicemail about treatment needs?	**YES**	**NO**
May we email you about appointment reminders?	**YES**	**NO**
May we email you about financial information?	**YES**	**NO**
May we email you about treatment needs?	**YES**	**NO**
May we email you about breach notification?	**YES**	**NO**

Email address:_____

Who else can we release information to (spouse, guardian)?

Name & relationship:_____

What can we discuss with them?

Appointment reminders?	**YES**	**NO**
Financial information?	**YES**	**NO**
Treatment needs?	**YES**	**NO**

Patient Rights

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to have email communications to occur as indicated above.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised November 2014