Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

_____ Signature _____ Date _____

Santo Lafoca DMD
Doreen Santos DMD
(570) 655-3040 / (570) 388-2131

PATIENT CANCELLATION/ NO SHOW POLICY

We recognize the value of your time and want your visit here to be a positive experience. We schedule patients so that our entire professional team has sufficient time set aside to meet you individual medical needs. **Please assist us in this effort by keeping your appointment and arriving on time, or by providing at least 24 hours advanced notice if you must cancel your appointment. If you are going to be MORE THEN 10 MINUTES LATE you need to reschedule, there are no exceptions.** In order to encourage participation in this policy; a fee will be added to your bill if you fail to give 24-hour cancellation notice by calling our office. The amount of this fee will depend on the amount of professional time that was reserved for you, and must be paid prior to rescheduling your next appointment. **We have a NO TOLERANCE POLICY FOR NO SHOWS/OR LATE CANCELATIONS. If you do not call or come to your scheduled appointment you will be dismissed from our practice and your records will be forwarded to a new provider of your choosing.**

We hope that this policy will ultimately benefit all patients by improving the quality of your diagnostic and treatment experience.

When you arrive for you appointment, please notify the receptionist. IF you arrived on time for your appointment, and then waited more than 20 minutes past your scheduled appointment time, please let the receptionist know. Sometimes cleanings and treatments take longer than anticipated. Please know that your needs will receive the very same attention and care when you are seen by our staff.

_____
(Patient Name, please print)

_____
(Patient or Guardian Signature)

_____
(Date)

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Doreen Santos DMD
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FINANCIAL POLICY AGREEMENT

RE: PRIVATE INSURANCE COVERAGE

For those who are covered by private insurance, we are pleased to extend the courtesy of billing your insurance company for you.

In order to provide this service for you we must have complete insurance information and confirmation of your coverage. We ask that you fill out all forms which give us the necessary information. It is our policy that anything not covered by insurance is to be paid in full at the time of service.

If you insurance company has not made payment within 90 days of billing, the balance will become the responsibility of the patient. Please remember that insurance is an agreement between the insured and the insurer. Therefore, if any problems arise with carrier, we will ask that you handle it with the insurance company. Our office will provide your insurance company with any additional information which may become necessary for resolution.

I understand and agree to honor my financial commitment to the office of Santo Lafoca and Associates as outlined above.

_____
(Patient Name, please print)

_____
(Patient or Guardian Signature)

_____
(Date)

Santo Lafoca DMD
Doreen Santos DMD
(570) 655-3040 / (570) 388-2131

DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM

Under the Health Insurance Portability and Accountability Act (HIPPA) of 1996, I have certain rights regarding the use and disclosure of my protected health information.

I hereby authorize the use and disclosure of my protected health information as indicated below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not this form to assure treatment through Dr. Santo Lafoca, Dr. Eric Smith, Dr. Doreen Santos, or any other dentist associated with this practice (herein referred to as Dr. Santo Lafoca and Associates).

I authorize Dr. Santo Lafoca and Associates to discuss my protected health information with and release any applicable medical information or records relating to my dental care to family members, staff, and any other qualified health care providers for treatment, payment, appointments, and health care operations as deemed necessary within their scope of practice.

In addition:

- I understand that I may revoke this authorization by written request at any time. I also understand that revocation will not apply to information that has already been released
- This authorization will not expire unless we are notified in writing that you wish to revoke this authorization. In that event, authorization will expire upon receipt of written notice.
- I understand that once information is released pursuant to this authorization, further re-disclosure of the information to another party cannot be prevented.
- I understand this authorization form must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered a valid original.

I have read this form and I understand its contents at this date.

_____
(Patient Name, please print)

_____
(Patient or Guardian Signature)

_____
(Date)

Santo Lafoca DMD
Doreen Santos DMD
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I _____, have received a copy of the office's Notice of Privacy Practices.

_____
(Patient Name, please print)

_____
(Patient or Guardian Signature)

_____
(Date)

OFFICE USE ONLY

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

_____

_____

_____