

Santo Lafoca DMD
Doreen Santos DMD
James Fruehan DMD
570-655-3040 Pittston/570-388-2131 Falls

PATIENT INFORMATION

Date _____

Patient # _____

SS# _____

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Circle one: Minor / Single / Married / Divorced / Widowed / Separated

Patient or Parent/Guardian's Employer _____

Address _____ City _____ State _____ Zip _____

Work Phone _____

Spouse or Parent/Guardian's Name _____

How did you hear about us? _____

Person to contact in case of emergency _____ Phone _____

(Patient Name, Please Print)

(Patient or Guardian Signature)

(Date)

20 N. Main Street, Pittston, PA 18640/2795 Sullivans Trail, Falls, PA 18615

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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 professional team has sufficient time set aside to meet your individual needs. Please assist in this effort by keeping your appointment and arriving on time. Please provide at least 24 hours advanced notice if you must cancel your appointment.

If you are going to be **more than 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 Cancellation fee is \$50 and must be paid prior to rescheduling your next appointment.

We have NO TOLERANCE POLICY for NO SHOWS/LATE CANCELLATIONS. 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 this policy will ultimately benefit all patients by improving the quality of your diagnostic and treatment experience.

When you arrive for your appointment please notify the receptionist. If you arrived on time for your appointment and have 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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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 that is NOT covered by insurance is to be paid in full at the time of service.

If your 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)

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DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 and Associates practice.

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)

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**

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)

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Medical History SC for

Completed by

on

Allergies

Are you allergic, or have you had a known reaction, to any of the following?

Aspirin (*select one*)

Yes

No

Unspecified

Codeine (or similar narcotics) (*select one*)

Yes

No

Unspecified

Local anesthetics (*select one*)

Yes

No

Unspecified

General anesthetics (*select one*)

Yes

No

Unspecified

Penicillin (or similar antibiotics) (*select one*)

Yes

No

Unspecified

Sulfa (or sulfur-containing) drugs (*select one*)

Yes

No

Unspecified

Latex or natural rubber (*select one*)

Yes

No

Unspecified

Barbiturates, sedatives, or sleeping pills (*select one*)

Yes

No

Unspecified

Certain foods (*select one*)

Yes

No

Unspecified

If yes, please specify

Hay fever, pollen, seasonal issues (*select one*)

Yes

No

Unspecified

Animal fur or dander (*select one*)

Yes

No

Unspecified

Iodine (*select one*)

Yes

No

Unspecified

Metals or metallic substances *(select one)* Yes No Unspecified

Other

Medical Conditions

Do you currently have (or have a history of) any of the following?

Abnormal bleeding *(select one)* Yes No UnspecifiedAngina *(select one)* Yes No UnspecifiedAlcohol abuse *(select one)* Yes No UnspecifiedAnemia *(select one)* Yes No UnspecifiedArthritis *(select one)* Yes No UnspecifiedArtificial heart *(select one)* Yes No UnspecifiedArtificial joints *(select one)* Yes No UnspecifiedAsthma *(select one)* Yes No UnspecifiedBlood transfusion *(select one)* Yes No UnspecifiedCancer / chemotherapy *(select one)* Yes No UnspecifiedColitis *(select one)* Yes No Unspecified

Congenital heart defects *(select one)*

Yes No Unspecified

Diabetes *(select one)*

Yes No Unspecified

Difficulty breathing *(select one)*

Yes No Unspecified

Drug abuse *(select one)*

Yes No Unspecified

Emphysema *(select one)*

Yes No Unspecified

Epilepsy *(select one)*

Yes No Unspecified

Fainting, dizziness, light-headedness *(select one)*

Yes No Unspecified

Fever blisters *(select one)*

Yes No Unspecified

Frequent headaches *(select one)*

Yes No Unspecified

Glaucoma *(select one)*

Yes No Unspecified

HIV / Aids *(select one)*

Yes No Unspecified

Hay fever *(select one)*

Yes No Unspecified

Heart attack / congestive heart failure *(select one)*

Yes No Unspecified

Heart surgery *(select one)*

Yes No Unspecified

Hemophilia *(select one)*

Yes No Unspecified

Hepatitis A or B *(select one)*

Yes No Unspecified

Hepatitis C *(select one)*

Yes No Unspecified

High blood pressure <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Kidney problems <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Liver disease <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Low blood pressure <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Mitral valve issues <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Pace maker <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Pneumocystis / pneumonia <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Psychiatric problems <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Radiation therapy <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Rheumatic fever <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Shingles <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Sickle cell disease <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Sinus issues / surgery <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Stroke <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Thyroid problems <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Organ transplant <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
Tuberculosis <i>(select one)</i>	<input type="radio"/> Yes	<input type="radio"/> No	Unspecified

Ulcers *(select one)*

<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
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Venereal disease *(select one)*

<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
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Yellow jaundice *(select one)*

<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
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Other

Additional Health Items

Do you currently use tobacco products? *(select one)*

<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
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Do you regularly drink alcohol? *(select one)*

<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
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Are you required to premedicate before any dental treatment? *(select one)*

<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
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Are you pregnant or nursing? (specify # of weeks) *(select one)*

<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
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If yes, please specify

Are you currently taking any medications? *(select one)*

<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
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If yes, please specify

Any other health issues you feel we should be aware of? *(select one)*

<input type="radio"/> Yes	<input type="radio"/> No	Unspecified
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If yes, please specify

Notes

Additional Notes

Signature

Printed Name

Date