Paul G. Lombardo, D.M.D.

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Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Please enter Employer and Occupation

_____

_____

Whom may we thank for referring you to our practice?

_____

Responsible Party Information:

Please enter information for the person financially responsible for the account

Please indicate Responsible Party *

◯ I am financially responsible for this account--Skip this section and continue to the next section.

◯ Other--Please fill out information below

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Dental Insurance Information

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

If you have Secondary Dental Insurance,
please present your insurance card to the front desk at the time of your appointment.

Dental History Information

What is the reason for your visit today?

_____

_____

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

_____

_____

Date of most recent dental exam and dental x-rays:

_____

_____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Check all that apply:

☐ Had complications from past dental treatment
☐ Had any reactions to local anesthetic
☐ Have dry mouth
☐ Food gets trapped between any teeth
☐ Have popping and/or clicking of your jaw joint
☐ Clench or grind your teeth
☐ Gums bleed when brushing or flossing
☐ Have or had gum recession
☐ Have or had a burning sensation in your mouth
☐ Would like to change the appearance of my smile
☐ Had trouble getting numb
☐ Had or have braces (orthodontic treatment)
☐ Teeth are sensitive to hot, cold, biting or sweets
☐ Have whitened or bleached your teeth
☐ Have difficulty chewing
☐ Wear or have worn a bite appliance
☐ Have been treated for gum disease
☐ Had an unpleasant taste or odor in your mouth
☐ Snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read below and sign at the bottom of the form.

1. Treatment to be Provided
I consent to all phases of diagnostic, preventative and restorative treatment deemed necessary as discussed with my healthcare provider.

2. Drugs and Medications
I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Informed Consent for General Dental Procedures.**

Broken Appointment/Cancellation Policy

If for any reason you are unable to keep your appointment, 24 hour advance notice must be given to avoid additional fee of $75.00.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Broken Appointment/Cancellation Policy.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

(Please enter name and relationship to patient.)

_____

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Name of person filling out this form: *

_____

_____

Relationship to patient: *

☐ Self ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Legal Guardian ☐ Other

Response Date: _____

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Medical History

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med
- ☐ Allergy-Aspirin
- ☐ Allergy-Latex
- ☐ Allergy-Other
- ☐ Alzheimer's Disease
- ☐ Asthma
- ☐ Blood Pressure-Low
- ☐ Cholesterol-High
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Attack
- ☐ Heart Pacemaker
- ☐ Joint replacement
- ☐ Lupus
- ☐ Respiratory Disorder
- ☐ STD / HPV
- ☐ Suppressed immune
- ☐ Ulcers
- ☐ Acid Reflux
- ☐ Allergy-Codeine
- ☐ Allergy-Metals
- ☐ Allergy-Penicillin
- ☐ Anemia
- ☐ Atrial fibrillation
- ☐ Cancer
- ☐ Crohn's Disease
- ☐ Easily Winded
- ☐ Fainting/Seizures
- ☐ Heart Disease
- ☐ Heart Valve Replacem
- ☐ Kidney Disease
- ☐ No Levo
- ☐ Rheumatic Fever
- ☐ Stent
- ☐ TB
- ☐ xnone
- ☐ ADHD
- ☐ Allergy-Erythro
- ☐ Allergy-Novocaine
- ☐ Allergy-Seasonal
- ☐ Anxiety
- ☐ Blood Disease
- ☐ Celiac disease
- ☐ Dementia/Alzheimer
- ☐ Emphysema
- ☐ Frequently Tired
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Leukemia
- ☐ Parkinson's Disease
- ☐ Rheumatoid arthritis
- ☐ Stomach Disorder
- ☐ Thyroid Disorder
- ☐ xOther Explain Below
- ☐ Allergy- Ibuprofen
- ☐ Allergy-Iodine
- ☐ Allergy-Nuts
- ☐ Allergy-Sulfa
- ☐ Arthritis
- ☐ Blood Pressure-High
- ☐ Chemo / Radiation
- ☐ Depression
- ☐ Endocrine
- ☐ Glaucoma
- ☐ Heart MVP
- ☐ HIV-Pos
- ☐ Liver Disease
- ☐ Psychiatric Care
- ☐ Shwannoma
- ☐ Stroke
- ☐ Ulcerative Colitis

☐ FEMALE: Pregnant or Planning Pregnancy ☐ FEMALE: Nursing

If any conditions or alerts selected above need further clarification, please describe below (including due date if pregnant):

_____

_____

_____

Do you use tobacco or nicotine? If yes, please check all that apply *

☐ Smoking ☐ Chewing ☐ Vaping ☐ Don't Use

Do you use controlled substances? * ◯ Yes ◯ No

Do you take antibiotic premedication for your dental visits? If yes, please explain below. * ◯ Yes ◯ No

PRE-MED

_____

_____

Are you taking any medications (prescription and non-prescription) including regular doses of aspirin or birth control pills? If yes, please list on next page *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

Have you taken or are you taking any Bisphosphonate drug used to treat osteoporosis or Paget's disease? Examples; Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa, Prolia etc. If yes, please enter the drug in the Medications list. *

◯ Yes ◯ No

Do you have any allergies not listed above (including allergies to foods, medications, sedatives, barbiturates)? If yes, please explain below *

◯ Yes ◯ No

ALLERGIES

Name of your Physician and phone number:

Name and phone number of preferred Pharmacy:

In an emergency who should be notified? Please enter Name and Phone number below:

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

☐ * By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

EXISTING PATIENTS ONLY
PLEASE UPDATE IF NECESSARY

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Response Date: _____