David M. Petrucco, DDS
Victoria A. Petrucco, DDS
115 Halstead Avenue
Harrison, NY 10528
(914) 835 -3488

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.

Personal Information

Today's Date _____

Name _____
D.O.B. _____
Soc. Sec. # _____
___Male ___Female ___Minor ___Single ___Married ___Other
Address _____
City, State, Zip _____
Email Address: _____
Employer_____ Occupation_____
Referred by _____
Home Phone _____Mobile#_____Work#_____
Where do you prefer to receive calls? ___Call Mobile ___Home ___Work
In event of an emergency, who should we contact?
Name_____Relationship _____
Mobile#_____ Home#_____Work#_____

Responsible Party (OMIT IF THIS IS SAME AS PATIENT)

Name _____
Relationship to patient _____
D.O.B._____
Driver's License #_____
Soc. Sec. # _____
Address _____
City, State, Zip _____
Employer _____
Occupation _____
Home Phone _____Mobile#_____
Work Phone _____

OFFICE USE ONLY

Remind patient to provide a photo ID, Insurance card, List of medications, and Form of payment when receiving the packet.

NP Intake Form Completed BY: _____

Patient Information Entered BY: _____

Patient Insurance Entered BY: _____

DL_____ INS____ LoM____ FoP____ PP_____

Dental Insurance Information

Primary Insurance

Name of Person Insured _____
Relationship to patient_____
Insured's birth date _____
Soc. Sec# _____
Employer _____
Date Employed _____
Occupation _____
Insurance Company _____
Group# _____
Subscriber# _____
Ins. Co. Address _____
Deductible _____
Amount already used _____

Additional Insurance

Name of Person Insured _____
Relationship to patient_____
Insured's birth date _____
Soc. Sec# _____
Employer _____
Date Employed _____
Occupation _____
Insurance Company _____
Group# _____
Subscriber# _____
Ins. Co. Address _____
Deductible _____
Amount already used _____

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Financial Arrangements

For your convenience, we will submit dental insurance claims to your insurance company for processing. **We require a credit card on file** to satisfy the remaining patient responsibility. Petrucco Dentistry requires a payment authorization to be completed prior to the start of any dental procedure.

Primary Card Account	**Secondary**
_____	_____
Credit Card #	
_____	_____
Name on credit card (as printed)	
_____	_____
Credit Card billing address	
_____/___/_____	_____/___/_____
City, State, Zip Code	
_____	_____
Card:(Visa, MC, Amex, CareCredit)	
____/____/_____(_____)	_____
Exp. Date Sec. code	

This authorization is valid until I provide Petrucco Dentistry PLLC with a written cancellation. This credit card authorization will allow Petrucco Dentistry PLLC to process the above credit card(s) for dental treatment. This approval form will be kept on file and only needs to be submitted again if the credit card(s) information changes.

Our participation in an insurance company does not guarantee payment of a claim.
It is the responsibility of the patient to check on coverage concerning dental benefits before receiving treatment.**

Late Charges
If I do not pay the entire balance, **after the day of service, a late charge of 1.5% on the balance** then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself [or my child] during the period of such Dental care to third party payers and/or other health practitioners.
I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.
I understand that my dental insurance carrier may pay less than the actual bill for services rendered on my behalf or my dependents.

X_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN IF MINOR **DATE**

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Health History

Name_____ D.O.B._____ Today's Date_____

Dental History

Reason for visit: _____
When was your last visit? _____
How often do you brush your teeth? _____
What texture toothbrush do you use? ___Soft ___Medium ___Hard
Do your gums bleed while brushing? **YES / NO**
Do your gums bleed when flossing? **YES / NO**
Do you feel pain to any of your teeth when brushing or flossing them? **YES / NO**
Are your teeth sensitive to hot, cold, sweet, or sour foods/liquids? **YES / NO**
Have you noticed any loosening of your teeth? **YES / NO**
Does food tend to be caught between your teeth? **YES / NO**
Do you have any sores or lumps in or near your mouth? **YES / NO**
Have you ever experienced any of the following problems in your jaw?
- Clicking? **YES / NO**
- Pain (joint, ear, side of face)? **YES / NO**
- Difficulty in opening or closing? **YES / NO**
- Difficulty in chewing? **YES / NO**

Have you had head, neck, or jaw injuries? **YES / NO**
Do you have frequent headaches? **YES / NO**
Do you clench or grind your teeth while awake or asleep? **YES / NO**
Do you bite your lips or cheeks frequently? **YES / NO**
Have you ever had:
- Orthodontic treatment (braces)? **YES / NO**
- Oral surgery? **YES / NO**
- Gum treatment? **YES / NO**
- Your teeth ground or bite adjusted? **YES / NO**
- Worn a bite plane or other appliance? **YES / NO**

Are you satisfied with the appearance of your teeth? **YES / NO**
Have you ever had an upsetting experience in a dental office? **YES / NO**
Is there anything about having dental treatment that bothers you? **YES / NO**

Medical History

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 that you may be receiving. Thank you for answering the following questions.

Are you in good health? **YES / NO**
Have there been any changes in your general health within the past year? **YES / NO**
Date of your last physical exam:_____
Physician's name _____
Address _____
Phone No. _____
Are you now under the care of a physician? **YES / NO**
Have you ever been hospitalized for any surgical operation or serious illness? **YES / NO**
Please explain. _____
Are you taking any medicine(s) including nonprescription medicine? **YES / NO**
If yes, what medicines are you taking?
_____
Have you ever had any abnormal bleeding? **YES / NO**
Do you bruise easily? **YES / NO**

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Have you ever required a blood transfusion? **YES / NO**
Have you had recent weight loss? **YES / NO**
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? **YES / NO**
Do you use tobacco? If yes, how may cigs/day/years?_____ **YES / NO**
Do you use alcohol? If yes, how many drinks/week?_____ **YES / NO**
Do you use cocaine or other drugs?_____ **YES / NO**
Are you wearing contact lenses? **YES / NO**
Do you have any disease, condition or problem not listed above that you think I should know about? **YES / NO**

Are you allergic to or have any reactions to:

Local anesthetics like novocaine? **YES / NO**
Barbiturates, sedatives, or sleeping pills? **YES / NO**
Penicillin or other antibiotics? **YES / NO**
Other? _____ **YES / NO**
Aspirin? **YES / NO**
Sulfa drugs? **YES / NO**
Iodine? **YES / NO**

Do you have or have you had any of the following:

Rheumatic heart disease or rheumatic fever? **Y/ N**
Scarlet fever? **Y/ N**
Heart defect or heart murmur? **Y/ N**
Heart trouble, heart attack or angina? **Y/ N**
-Do you have pain in your chest upon exertion? **Y/ N**
- Are you ever short of breath after mild exercise? **Y/ N**
-Do your ankles swell? **Y/ N**
-Do you get short of breath when you lie down? **Y/ N**
-Do you require extra pillows when you sleep? **Y/ N**
Pace maker? **Y/ N**
Heart surgery? **Y/ N**
Cough that produces blood? **Y/ N**
Cancer? **Y/ N**
Sexually transmitted disease? **Y/ N**
Epilepsy? **Y/ N**
Anemia? **Y/ N**
Leukemia? **Y/ N**
Glaucoma? **Y/ N**
High blood pressure? **Y/ N**
Low blood pressure? **Y/ N**
Hepatitis, jaundice, or liver disease? **Y/ N**
Stroke? **Y/ N**
Sinus trouble? **Y/ N**
Lung or breathing problems? **Y/ N**
Asthma or hay fever? **Y/ N**
Hives or skin rash? **Y/ N**
Fainting spells or seizures? **Y/ N**
Diabetes? **Y/ N**
AIDS or HIV infection? **Y/ N**
Thyroid problems? **Y/ N**
Allergies? **Y/ N**
Arthritis or rheumatism? **Y/ N**
Joint replacement or implant? **Y/ N**
Stomach ulcer? **Y/ N**
Kidney trouble? **Y/ N**
Tuberculosis? **Y/ N**
Persistent cough? **Y/ N**

Women only:
Are you pregnant or think you may be pregnant? **YES / NO**
Are you nursing? **YES / NO**
Are you taking birth control pills? **YES / NO**

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.

X_____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN IF MINOR **DATE**

X_____
SIGNATURE OF DOCTOR **DATE**

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Finance Options

Dear Patient,

We are pleased to welcome you as a new patient. Our primary mission at Dr. Petrucco's office is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. We are happy to offer these choices so that you can select a payment option that best fits your needs.

To assist you with your dental care investment, we provide the following payment options:

1. **Cash** – includes money orders, debit cards, and personal checks.

2. **Credit Cards: Visa, MasterCard, Discover, and American Express**

3. **Flex Spending Accounts**

4. **CareCredit®** – patient payment plans that allow you to pay over time with convenient low minimum monthly payments. With CareCredit, you enjoy these benefits:*
   - Flexible financing options
   - No annual fees or prepayment penalties
   - Quick and easy application
   - Receive a credit decision almost immediately
   - Start your recommended treatment immediately*

5. **Dental Insurance** – While dental insurance is not issued by our office, we will make all reasonable efforts to aid you in having your treatment properly benefited. Any treatment fees not paid by your insurance company are the patient's responsibility and can be paid by any of the above four methods. **As per PPO agreements, patients must fulfill their financial obligation at the time of treatment.**

   Our participation in an insurance company does not guarantee payment of a claim. It is the responsibility of the patient to check on coverage concerning dental benefits before receiving treatment. **For more information on how dental insurance works, we ask that you review the provided Dental Insurance pamphlet.**

Patient Responsibility

Our participation in an insurance company does not guarantee full payment by the insurance company towards their fee schedule of a claim. *It is the responsibility of the patient to check on coverage concerning dental benefits before receiving treatment.* Past due accounts are subject to a 1.5% monthly (18% Annually) finance charge.

This office will submit claims to, and possibly accept assignment of benefits from, your dental insurance carrier as a courtesy to our patients. We do not issue, guarantee, or provide dental coverage for the treatment performed in this office. Any claims not processed within 60 days of the date of submission, and any benefits not paid by the insurance company, are the patient's responsibility. It is also the patient's responsibility to verify eligibility, deductibles, and benefit levels.

I have read this full packet, filled out all necessary information, and understand my patient responsibility for any treatments provided by Petrucco Dentistry PLLC.

_____ _____

Patient's or Responsible Party Signature Today's Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment, or health care operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with this practice."

"It is our policy to provide a substitute health care provider, authorized by this practice, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to this practice for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury, or condition, and codes which describe the health care services received."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and immanent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership

In the event that this practice is sold or merged with another organization, your health information/record will become the property of a new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by this practice.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.