New Patient Questionnaire Today's Date _____

First Name: _____ Last Name: _____

Preferred Nickname: _____ Date of Birth: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Patient's Social Security Number: _____

General Dentist: _____

Primary Dental Insurance: _____

Policy Holder's Name: _____

Policy#/ID#/Member ID: _____ Group #: _____

Policy Holder's SS#: _____ DOB: _____

Employer Name: _____ Work Phone: _____

Relationship to the patient: Spouse ____ Parent ____ Self ____ Other _____

Medical Insurance: _____

Policy Holder's Name: _____

Policy#/ID#/Member ID: _____

Policy Holder's SS#: _____ DOB: _____

Employer Name: _____ Work Phone: _____

Relationship to the patient: Spouse ____ Parent ____ Self ____ Other _____

Emergency Contact

Name: _____

Phone #: _____

Relationship to the patient: _____

Current Medications: _____

_____

_____

_____

Allergies to Medications: _____

_____

_____

_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. If this account is assigned to an attorney for collection, prevailing party shall be entitled to reasonable attorney's fees and cost of collections. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and/or surgical benefits to which I am entitled to include major medical benefits, private or other health plans to John N. Santin, DDS, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature of Patient or Legal Guardian: _____

Date: _____

PATIENT NAME DATE OF BIRTH HEIGHT WEIGHT

*ANSWER ALL QUESTIONS BY CIRCLING Y or N

**ALL RESPONSES KEPT CONFIDENTIAL

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

_____

_____

6. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Do you have obstructive sleep apnea ..... Y N
   - F. Do you use a CPAP machine ..... Y N
   - G. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ..... Y N
   - H. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Osteoporosis? ..... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - P. Radiation (X-ray) treatment for Cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - R. Sinus or Nasal problems? ..... Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
   - T. Have you been tested for AIDS/HIV? ..... Y N
   - U. Do you have AIDS/HIV? ..... Y N
7. ARE YOU USING ANY OF THE FOLLOWING:
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia) ? ..... Y N
   - J. Have you ever been advised <u>not</u> to take a medication? ..... Y N
   - K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

_____

_____

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
   - A. Local Anesthesia (Novacaine, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber products? ..... Y N
   - G. Metal of any kind? ..... Y N
   - H. Chemicals or jewelry (rash or sensitivity)? ..... Y N
   - I. Food products? ..... Y N
   - J. Other allergies or reactions? Please list ..... Y N

_____

_____

9. Do you smoke or chew Tobacco? ..... Y N
   How much per day? _____
   Have you ever smoked or chewed tobacco? ..... Y N
   How much? _____
   How long? _____
10. Is there any current or past history of Alcohol or Chemical Dependency or Emotional Disorder? ..... Y N
    Do you currently or have you ever used recreational drugs? ..... Y N
11. Have you had any serious problems associated with any previous dental treatment? ..... Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
14. Do you wish to talk to the doctor privately about anything? ..... Y N
15. Have you ever had a bone density scan? ..... Y N
16. FOR WOMEN ONLY
    - A. Are you Pregnant, or <u>is there any chance</u> you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N

I understand the importance of a truthful and complete health history to assist my dentist in providing the best care possible. I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

_____ _____ _____

Date Patient/Responsible Party Signature Doctor's Initial

HIPAA SIGNATURE SHEET

This form is to simply acknowledge that you HAVE THE OPPORTUNITY to receive your own copy of our HIPAA privacy policy.

I, _____

(PATIENT/RESPONSIBLE PARTY NAME) (DATE)

hereby acknowledge that I have seen and been given the opportunity to receive a copy of John N. Santin, D.D.S, INC. Notice of Privacy Practices. I will be given the opportunity to ask any questions that I may have regarding this notice.

**Our policy pertaining to HIPAA is available upon request. Please let our front office staff know you would like a copy.*

FINANCIAL CONSENT FORM

Our office processes your insurance to the best of our ability as a courtesy to you. Any copay and/or estimated out of pocket expenses must be prepaid prior to treatment. ½ of your estimated out of pocket is required to schedule the surgery/procedure and the other ½ of due the day of treatment.

Your insurance company never gives an exact amount they will pay. **IT IS ALWAYS AN ESTIMATE**. You are responsible for any remaining balance that your insurance does not pay.

_____

Patient/Responsible Party Signature Date