Welcome to Our Practice

PATIENT INFORMATION:

Today's Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name_____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date_____Age____ Soc. Sec. #_____ E-mail _____

Street_____Apt.____ City_____State_____ Zip _____

Home Tel. (_____) _____ Cell (____) _____ Have you ever been a patient of our practice? ❑Yes ❑ No

Referred By _____ _____ Has a family member ever been a patient of our practice? ❑Yes ❑ No
FIRST NAME LAST NAME

Dentist_____ _____ Orthodontist_____ _____ Medical Dr._____ _____
FIRST NAME LAST NAME FIRST NAME LAST NAME FIRST NAME LAST NAME

Drivers Lic. #_____ Nearest Relative not living with you _____ _____ Tel. (____) _____

Employer _____ Bus. Tel. (____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other_____

Name _____ _____ S.S.#_____ Birth Date _____ Age _____
FIRST NAME LAST NAME

Tel. (___) _____ Cell (___) _____ E-mail_____

Street_____Apt._____ City_____ State_____ Zip _____

Driver's Lic. #_____ Employer_____ Bus. Tel. (_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name _____ _____ Relation _____S.S.#_____ Birth Date _____
FIRST NAME LAST NAME

Street_____Apt._____ City_____ State_____ Zip _____

Tel. (___) _____ Employer_____ Bus. Tel. (_____) _____

INSURANCE INFORMATION:

Student . . . . . ❑ Full Time ❑ Part Time ❑ N/A . . . . . School Name and Address _____ _____
SCHOOL NAME ADDRESS

Marital Status . . . . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ _____
CITY STATE ZIP

Employed. . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ N/A . . . . . Do you belong to a PPO or HMO? ❑Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address _____ _____ ____ ____
ADDRESS CITY STATE ZIP

Bus. Tel. (___)_____ Plan _____

Ins. Co. Name _____ I.D. #_____

Address _____ _____ ____ ____
ADDRESS CITY STATE ZIP

Tel. (___)_____ Group Name _____

Group # _____ Insured Party_____ _____
FIRST NAME LAST NAME

Relation _____ Birth Date_____ Sex: ❑ M ❑ F

S.S. # _____ Tel. (___) _____

Address _____ _____ ____ ____
ADDRESS CITY STATE ZIP

PRIMARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address _____ _____ ____ ____
ADDRESS CITY STATE ZIP

Bus. Tel. (___)_____ Plan _____

Ins. Co. Name _____ I.D. #_____

Address _____ _____ ____ ____
ADDRESS CITY STATE ZIP

Tel. (___)_____ Group Name _____

Group # _____ Insured Party_____ _____
FIRST NAME LAST NAME

Relation _____ Birth Date_____ Sex: ❑ M ❑ F

S.S. # _____ Tel. (___) _____

Address _____ _____ ____ ____
ADDRESS CITY STATE ZIP

SECONDARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address _____ _____ ____ ____
ADDRESS CITY STATE ZIP

Bus. Tel. (___)_____ Plan _____

Ins. Co. Name _____ I.D. #_____

Address _____ _____ ____ ____
ADDRESS CITY STATE ZIP

Tel. (___)_____ Group Name _____

Group # _____ Insured Party_____ _____
FIRST NAME LAST NAME

Relation _____ Birth Date_____ Sex: ❑ M ❑ F

S.S. # _____ Tel. (___) _____

Address _____ _____ ____ ____
ADDRESS CITY STATE ZIP

SECONDARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address _____ _____ ____ ____
ADDRESS CITY STATE ZIP

Bus. Tel. (___)_____ Plan _____

Ins. Co. Name _____ I.D. #_____

Address _____ _____ ____ ____
ADDRESS CITY STATE ZIP

Tel. (___)_____ Group Name _____

Group # _____ Insured Party_____ _____
FIRST NAME LAST NAME

Relation _____ Birth Date_____ Sex: ❑ M ❑ F

S.S. # _____ Tel. (___) _____

Address _____ _____ ____ ____
ADDRESS CITY STATE ZIP

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

		Yes	No
1.	Have there been any changes in your general health in the past year?	❑	❑
2.	Are you under the care of a physician? *Date of last visit* _____	❑	❑
	If so, for what are you being treated? _____		
3.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe _____		
	_____		
	_____		

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
4. Damaged heart valves / mitral valve prolapse?		
5. Heart murmur?		
6. High blood pressure?		
7. Chest pain / angina?		
8. Heart attack(s)?		
9. Irregular heart beat?		
10. Cardiac pacemaker?		
11. Heart Surgery?		
12. Pneumonia, bronchitis, chronic cough?		
13. Asthma?		
14. Sinus problems?		
15. Snoring?		
16. Sleep apnea / CPAP?		
17. Difficult breathing/other lung trouble?		
18. Tuberculosis?		
19. Emphysema?		
20. Do you smoke? If so, number of packs a day_____		
21. Do you use chewing tobacco?		
22. Blood disorder such as anemia?		
23. Bruise easily?		
24. Bleeding tendency / abnormal bleed?		
25. Hepatitis, jaundice, or liver disease?		
26. Infectious mononucleosis?		
27. Fainting spells?		

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
28. Convulsions / epilepsy?		
29. Stroke?		
30. Thyroid trouble?		
31. Diabetes?		
32. Kidney trouble?		
33. Swollen ankles / arthritis / joint disease?		
34. Osteoporosis / osteopenia?		
35. Stomach ulcers / acid reflux?		
36. Contagious diseases?		
37. Sexually transmitted diseases?		
38. HIV/AIDS?		
39. Problems with immune system? Possibly from medication / surgery, etc.		
40. Delay in healing?		
41. A tumor or growth?		
42. Cancer / radiation therapy / chemotherapy?		
43. If breast cancer, which side?		
44. A history of alcohol abuse?		
45. A history of drug abuse?		
46. A history of cold sores?		
47. Eye disease / glaucoma?		
48. Mental health problems / anxiety / depression?		
49. A removable dental appliance?		
50. Pain or clicking of jaws when eating?		
51. Do you haverRestless leg syndrome?		

WOMEN ONLY: *(QUESTIONS 51 – 53)*

	Yes	No
52. Is there a possibility of pregnancy?	❑	❑
53. Expected delivery date? _____		

	Yes	No
43. Are you nursing?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO
54. Any kind of medication, drug, pills?		
56. Blood thinners (Coumadin, Plavix, Aspirin, Xarelto, Eliquis, Aggrenox, Pradaxa, Other)?		
57. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphos-phonates such as Denosumab, Fosamax, Boniva, or Actonel?		
58. Are you taking, or have you ever taken IV bone density meds, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years?		
59. Are you under the care of a pain clinic?		
60. Do you receive prescription OPIOIDS? If yes, name of prescription_____		
61. Do you receive an ongoing or recurring prescription to treat OPIOID addiction or other addictions? If yes, name of prescription_____ Do you have a contract with them? If yes, please provide the following: Name of Treatment Center:_____ Name of Doctor:_____		
62. Do you take tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis?		
If yes, please list:		
63. Do you take any natural product, herbal supplement or homeopathic remedy?		

64. Please list any medications you are currently taking:

Medication	Start Date	Dosage	Frequency

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO
65. Penicillin?		
66. Sulfa drugs?		
67. Sodium pentothal / Valium / other tranquilizers?		
68. Aspirin?		
69. Codeine or other narcotics?		
70. Latex?		
71. Soy?		
72. Eggs / yolk?		

THINGS THAT COULD AFFECT YOUR ANESTHESIA:	YES	NO
73. Have you or any family members had any adverse reaction to anesthesia? If yes, explain_____		
74. Do you have sleep apnea or use a C-PAP / BiPAP mask?		
75. Do you have difficult veins when having blood drawn or if you have an IV?		
76. Do you have anxiety or panic attacks? If yes, how often?_____ During Dental appointments?		
77. Do you gag easily, such as when having x-rays taken?		
78. Do you use an inhaler? If yes, how often?_____		
79. Do you or have you taken doses of steroids for at least 2 months in the last 2 years, such as Prednisone? If yes, how long did you take them?___ Have you stopped? If yes, when?_____		
80. Do you use marijuana in any form? If yes, daily, weekly, monthly?		

Is there any health question you answered YES to or condition concerning your health that the Doctor should be told about? Please describe:

THINGS THAT COULD AFFECT HEALING/SURGERY:	YES	NO
81. Have you had any of the following: recurrent strep throat, ear infections, bronchitis, sinus infections, Lyme, staph infections, C.DIFF?		
82. History of taking medications for acne?		
83. Do you pre-medicate with antibiotics prior to dental appointments due to having an artificial joint or heart valve replacement or other?		
84. How many times in your LIFETIME have you taken antibiotics (IV, Oral, IM) ?		
85. Do you have difficulty opening your mouth wide?		
86. Do you grind or clench your teeth?		
87. Are you taking birth control pills?		

Is there any health question you answered YES to or condition concerning your health that the Doctor should be told about? Please describe:

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **X** _____ **X** _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* Date Reviewed by Date

LOUIS F. CLARIZIO, DDS PA

ORAL SURGERY & DENTAL IMPLANT CENTER

Diplomate, American Board of Oral & Maxillofacial Surgery

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT AND NOTICE OF POLICIES

Your signature below forms a binding agreement between Louis F. Clarizio, D.D.S. P.A. (the provider of services) and the Patient who is receiving services, or the Responsible Party (when applicable). Responsible Party is the individual who is financially responsible for payment of bills.

For patients without insurance benefits, or if this is a liability claim, payment is due in full at time of service. For patients with insurance benefits, payment is due in full within 30 days of receiving a statement.

MEDICAL/DENTAL INSURANCE: Our office will offer assistance in maximizing your insurance benefits, however; **PATIENTS ARE RESPONSIBLE FOR CONFIRMING THEIR OWN INSURANCE BENEFITS.** We have contracts with many insurance companies, and we will bill them as a service to you. Please be aware, insurance companies do not guarantee payment. Our office can only **ESTIMATE** the approximate percentage or amount that your insurance may pay. Some or perhaps all of the services may not be considered reasonable and necessary under your insurance plan. In this instance, as the Responsible Party, you are responsible if your insurance company declines to pay for any reason.

The Patient or the Responsible Party must:

- Inform Louis F. Clarizio, D.D.S. P.A. of the current address and phone number for the patient and the Responsible Party.
- Present all current insurance cards prior to each office visit.
- Contact medical and/or dental insurance company to confirm coverage.
- Verify at each visit that the information is current.
- Pay any required copay or portion insurance will not cover at time of visit.
- Pay any balance due in full within 30 days of receiving a statement from our office. ***Partial payments will not be accepted.***

PAYMENT ARRANGEMENTS: For your convenience we accept all major credit cards, cash and checks drawn from local banks. We do not accept postdated checks. Extended payment plans are available through corporate financing (CareCredit) and we can easily assist you with the application process, which must be completed and approved prior to the actual procedure.

RETURNED CHECK POLICY: If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), or Account Closed (AC), the Patient or Patient's Responsible Party will be responsible for the original check amount in addition to a $30.00 Service Charge. Once notified by our office, if payment in full is not made within 15 days by the Patient or Responsible Party, the account may be turned over to our collection agency. Patients who allow their account to go to collections will be expected to pay in full for all future services, or may be dismissed from the practice.

COLLECTION FEES AND EXPENSES: You understand and acknowledge that you are responsible for any fees or expenses, including reasonable attorney's fees and collection agency fees incurred by Louis F. Clarizio, D.D.S. P.A. in collecting any balances due under the terms of this Agreement. Fees will be in addition to the balance due.

(Continued on other side)

566 Islington Street, Portsmouth, NH 03801
603.436.8222 Voice 603.433.3299 Fax

www.drclarizio.com

504 High Street, Somersworth, NH 03878
603.436.8222 Voice 603.749.1707 Fax

PRE-AUTHORIZATION AND REFERRALS: Many insurance carriers require a referral from your Primary Care Physician (PCP), before you receive care from a specialist; it is your responsibility to obtain a referral or prior authorization if your medical coverage requires it.

PRE-DETERMINATIONS: Upon request from you we will submit a pre-determination to your dental insurance to help you verify your coverage before surgery. Results from pre-determinations may take anywhere from 3-6 weeks depending on your insurance company. **Remember, a pre-determination does not guarantee an insurance payment; it is only another way to attempt to determine what your insurance plan may pay**.

NO SHOW/MISSED APPOINTMENT POLICY: We request notice of at least 24 hours for cancellation of appointments. If appropriate notice is not given, a $25 charge (for consultation appointment) or a $50 charge (for surgery appointment) may be assessed to the patient's account. We understand that sometimes last minute cancellations are unavoidable. If this is the case, please call the office as soon as possible. Our schedule fills up quickly, and this will allow us to reallocate those slots to other patients. Patients who miss appointments may be dismissed from the practice.

NOTICE OF NON-COVERED SERVICES: The doctor may recommend a procedure that is not a covered benefit with your carrier. Insurance carriers will only pay for services that are covered by your particular plan and they consider medically necessary. Some services, such as anesthesia, may not be a covered benefit; however, the doctor will not base your plan of care on insurance coverage. All non-covered services must be paid in full at the time of service. In cases where your insurance company denies payment for services rendered, you are responsible for payment of your treatment.

Divorced/Separated Parents: *Please be advised that in the event of any dispute between parents/guardians about who will be responsible for amounts due, or who gets the refund, etc., the party initiating the treatment and signing this PATIENT FINANCIAL RESPONSIBILITY AGREEMENT AND NOTICE OF POLICIES is deemed financially responsible for the account. Failure to arrive at your appointment with the estimated balance due in full will require us to reschedule.* ***We do not get involved in such disputes.***

REFUNDS: Refunds are processed at the end of the month and mailed to the patient or responsible party. **Please Note:** There will be a $25.00 stop payment fee for lost checks. Your entitlement to a refund may depend on the following:

- If the account shows a current balance.
- If the insurance company is requesting monies returned or there is a discrepancy in their payment to us.
- If there is a question as to the status/eligibility of insurance coverage.
- If you have made a deposit and are still seeking treatment.
- If we are awaiting payment from your insurance.

Please indicate the method of payment you plan to use for your consultation appointment:

❑ Cash ❑ Check ❑ Charge ❑ Submit to Dental Insurance

By signing below, you agree to accept FULL FINANCIAL RESPONSIBILITY as Patient who is receiving services or as the Guarantor for the patient. You authorize payment of benefits to Louis F. Clarizio, D.D.S. P.A. Your signature verifies that you have read the above, had the opportunity to ask and have answered any questions, understand your responsibilities, and agree to these terms.

_____ Date _____

Signature of Responsible Party: Patient or Guarantor (if patient is a minor)

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