Welcome to Our Practice

PATIENT INFORMATION:

Today's Date 04/11/2023

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name ______ M.I. ______ Last Name ______

Sex: ❑ Male ❑ Female Birth Date ______ Age ______ Soc. Sec. # ______ E-mail ______

Street ______ Apt. ______ City ______ State ______ ______

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

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

Dentist ______ (FIRST NAME) ______ (LAST NAME) Orthodontist ______ (FIRST NAME) ______ (LAST NAME) Medical Dr. ______ (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 ______ (FIRST NAME) ______ (LAST NAME) S.S.# ______ Birth Date ______ Age ______

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 ______ (FIRST NAME) ______ (LAST NAME) Relation ______ S.S.# ______ Birth Date ______

Street ______ Apt. ______ City ______ State ______ Zip ______

Tel. (____) ______ Employer ______ Bus. Tel. (____) ______

INSURANCE INFORMATION:

Student . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . School Name and Address ______ (SCHOOL NAME) ______ (ADDRESS)

Marital Status . . . . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated ______ (CITY) ______ (STATE) (ZIP)

Employed. . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not . . . . 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	NOTES
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. Snoring?			
15. COVID or vaccine-related issues?			
16. Difficult breathing/other lung trouble?			
17. Tuberculosis?			
18. Emphysema?			
19. Do you use chewing tobacco?			
20. Blood disorder such as anemia?			
21. Bruise easily?			
22. Bleeding tendency / abnormal bleed?			
23. Hepatitis, jaundice, or liver disease?			
24. Infectious mononucleosis?			
25. Fainting spells?			

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

WOMEN ONLY: *(QUESTIONS 49 – 51)*

	Yes	No
49. Is there a possibility of pregnancy?	❑	❑
51. Are you nursing?	❑	❑

50. Expected delivery date?___________________________

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	NOTES
52. Any kind of medication, drug, pills?			
53. Blood thinners (Coumadin, Plavix, Aspirin, Xarelto, Eliquis, Aggrenox, Pradaxa, Other)?			
54. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, or Actonel?			
55. Are you taking, or have you ever taken IV bone density meds, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years?			
56. Are you under the care of a pain clinic?			
57. Do you receive prescription OPIOIDS? If yes, name of prescription__________			
58. 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:________________			
59. Do you take tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If yes, please list:			
60. Do you take any natural product, herbal supplement or homeopathic remedy?			

61. Please list any medications you are currently taking:

Medication	Start Date	Dosage	Frequency

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

THINGS THAT COULD AFFECT YOUR ANESTHESIA:	YES	NO	NOTES
70. Have you or any family members had any adverse reaction to anesthesia? If yes, explain__________________			
71. Do you have sleep apnea or use a C-PAP / BiPAP mask?			
72. Do you have difficult veins when having blood drawn or if you have an IV?			
73. Do you have anxiety or panic attacks? If yes, how often?________________ During Dental appointments?			
74. Do you gag easily, such as when having x-rays taken?			
75. Do you use an inhaler? If yes, how often?________________			
76. 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?___________________			
77. Do you use marijuana in any form? If yes, what form?_________________ Frequency: ❑ Daily ❑ Weekly ❑ Monthly ❑ Other________________________			

Is there any condition concerning your health that the Doctor should be told about: ❑ No ❑ Yes – Please describe:

THINGS THAT COULD AFFECT HEALING/SURGERY:	YES	NO	NOTES
81. Have you had any of the following: recurrent strep throat, ear infections, bronchitis, sinus infections, Lyme, staph infections, C.DIFF?			
82. Sinus problems or surgery?			
83. History of taking Accutane for acne?			
84. Do you pre-medicate with antibiotics prior to dental appointments due to having an artificial joint or heart valve replacement or other?			
85. Have you taken antibiotics before? (IV, Oral, IM)			
86. Do you have difficulty opening your mouth wide?			
87. Do you grind or clench your teeth?			
88. Do you wear a night guard?			
89. Are you taking birth control pills, IUD, or depo-provera injections?			
90. Do you smoke? If so, number of packs a day__________			
91. Delayed healing?			

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 ______________________________
Signature of patient *(Parent or Guardian if Minor)*

X ______________________
Date

X ______________________
Reviewed by

X ______________________
Date

STAFF NOTES: *(Patient do not write in this area)*

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. *Partial payments will not be accepted.

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. We will deduct the insurance **estimate** from your total, and your out of pocket will be due prior to your surgery.

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.
- Contact medical and/or dental insurance company to confirm coverage.
- Pay any required copay and/or estimated portion due on date of service.
- Pay any balance due in full within 30 days of receiving a statement from our office.

PAYMENT ARRANGEMENTS: For estimate amounts less than $2000, we accept all major credit cards, cash and checks drawn from local banks. We do not accept postdated checks. For all other amounts we require a credit card or certified bank check in place of a personal check. For all estimate amounts over $5,000, we require payment one week prior to surgery, or your appointment may be rescheduled. 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. All future appointments after going to collections, payment must be paid in full, regardless of your insurance. You will be reimbursed after your insurance company has made their payment.

(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.

Responsible Party Information (Please fill out and sign below):

Name_______________ _______________________ Relation_________________ DOB______
First Name Last Name

Mailing Address_____________________________City____________________State____Zip______

Tel. (____) _______________Employer__________________________Bus. Tel. (____) ____________

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)