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 Our Mission Statement:

To provide our community with the highest standard of dental care. In providing this exceptional care, we plan to cultivate satisfied, appreciative, and prevention-oriented patients. With quality care as our focus, we will strive to exceed our patient’s expectations with respect to customer service, friendliness and compassion.

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Nickname* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apartment # \_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Male / Female Married / Single

Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL for appointment reminders:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were your **referred** here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID # or SS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of card holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date of card holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TURN OVER**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Dentist’s Name Date of last cleaning Date of last dental work

Do you have any *dental problems* such as:

\* Do your gums bleed? Yes No

\* CIRCLE which appliance you currently wear: Dentures Partials Nightguard

\* CIRCLE which dental concern you currently have: Grinding Clenching TMJ

The name & phone # of your General Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medical condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List **any** and **ALL** medicine(s) including non-prescription, homeopathic or “Natural” remedies including diet pills?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **CIRCLE each Yes or No**

 Damaged heart valves, artificial valves, Congenital Heart defects.…CIRCLE each condition………………………… Yes No

 Bacterial Endocarditis………………………………………………………………………………………………………… Yes No

 Pacemaker……………………………………………………………………………………………………………………….. Yes No

 Rheumatic Heart Disease………………………………………………………………………………………………………. Yes No

 Heart trouble, Heart attack, Angina, Stroke, Arteriosclerosis…………CIRCLE each condition …………… Yes No

 Prosthetic Joint Replacement..………………………………………………………………………………………………… Yes No

 High / Low Blood Pressure ……………………….…………………………………………………….……………………… Yes No

 High / Low Cholesterol ………………………………………………………………………………………………………..…. Yes No

 Latex Sensitivity……………………………………………………………………………………………………………… … Yes No

 Asthma or hay fever…………………………………………………………………………………………………………… Yes No

 Seizures, Epilepsy………………………………………………………………………………………………………………. Yes No

 Diabetes…………………………………………………………………………………………………………………………. Yes No

 Hepatitis………………………….……………………………………………………………………………………………… Yes No

 Liver Disease…………………………………………………………………………………………………………………… Yes No

 Alzheimer’s, Dementia CIRCLE each condition Yes No

 Autism, Learning Disabilities, Sensory Disabilities CIRCLE each condition Yes No

 Frequent or recurring mouth sores…………………………………………………………………………………………… Yes No

 Thyroid problems……………………………………………………………………………………………………………….. Yes No

 Respiratory problems, emphysema, bronchitis ….………CIRCLE each condition …………………... Yes No

 Arthritis…………………………………………………………………………………………………………………………….. Yes No

 Stomach ulcer or hyperacidity………………………………………………………………………………………………….. Yes No

 Kidney trouble…………………………………………………………………………………………………………………….. Yes No

 Tuberculosis…………………………………………………………………………………………………………………….. Yes No

 HIV / AIDS………………………………………………………………………………………………………………………… Yes No

 Cancer…………………………………………………………………………………………………………………………… Yes No

 If Yes to any of the above, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What year \_\_\_\_\_\_\_\_

 Radiation treatment Yes No If yes, body location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have or have you had any disease, condition, or problem not listed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you ***allergic*** to any medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other allergies (Please include: foods, such as eggs, metals, etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke or use Tobacco Yes No Do you drink alcohol? Yes No

Are you Pregnant? Yes No, due date:\_\_\_\_\_\_\_\_\_\_\_\_ Are you taking birth control pills? Yes No

Hospitalized/surgery in last 6 months Yes No if yes, reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COVID vaccine Moderna Pfizer J & J \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 1st date 2nd date Booster

***Signature***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TURN OVER**

**PATIENT CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected dental health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

\* Treatment (including direct or indirect treatment by other healthcare providers involved).

\* Obtaining payment from third party payers (i.e. my insurance company).

\* The day-to-day healthcare operations of your practice, such as:

 - Sending a recall appointment reminder to my home.

- Leaving appointment, billing or dental information on my answering machine/voicemail/e-mail.

- Giving permission to share appointment, billing, or dental information with people at my contact address or contact telephone numbers.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected dental health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at anytime to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected dental health information is used and disclosed to carry out treatment, but that you are then bound to comply with this restriction.

Patients, family members, and anyone accompanying the patient will not be permitted to use inappropriate behavior or language directed towards the physicians or the office staff. This also applies during telephone conversations. This type of inappropriate behavior may result in discharge from this practice.

I authorize Verardi Dental to utilize my cosmetic teeth photos for educational purposes.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Do you have or had a fever in last 14-21 days Y / N

Any other flu like symptoms (headache, fatigue) Y / N

Are you in contact with any confirmed COVID 19 patients Y / N

***Signature***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Turn Over**

**Financial Policy Agreement, Cancellation/No Show Policy, Assignment of Benefits, General Authorizations**

Thank you for choosing Verardi Dental as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please read carefully and sign below. You may request a copy.

**I authorize the following name(s) to have access to my dental information.**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Payment** *is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express and Discover. Outside financing is available through Care Credit upon approval.*

**Cancellation & No Show Policy**: *Rescheduling must be given 24 hours before the appointment time. You may be rescheduled if you are more than 10 minutes late and you will be charged a $50 cancellation fee if you do not show for your scheduled appointment or if you cancel within 24 hours of your appointment. If you fail to keep more than 2 appointments without advance notification, you may be restricted to a walk in or time available basis.*

As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you. However it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

At Verardi Dental we are committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payments directly to Verardi Dental.

Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Verardi Dental.

**Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date