PATIENT INFORMATION – GENERAL:

NAME: _____ DATE: _____

FIRST MI LAST

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH (MM/DD/YYYY): _____ SOCIAL SECURITY #: _____

PRIMARY PHONE #: _____ CELL ☐ HOME ☐ E-MAIL: _____

SECONDARY PHONE #: _____ CELL ☐ HOME ☐ DRIVER'S LICENSE #: _____

CHECK APPROPRIATE BOX: MINOR - ☐ SINGLE - ☐ MARRIED - ☐ DIVORCED - ☐ WIDOWED - ☐ SEPARATED - ☐

WHOM MAY WE THANK FOR REFERRING YOU? _____

EMERGENCY CONTACT:

NAME: _____ PHONE #: _____

FIRST LAST

RESPONSIBLE PARTY:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _____

*****IF PERSON RESPONSIBLE FOR THIS ACCOUNT IS THE PATIENT, AND ALL OF THE INFORMATION IS THE SAME AS ABOVE, PLEASE CHECK THIS BOX AND CONTINUE TO THE 'INSURANCE' SECTION OF THIS FORM:** ☐

RELATIONSHIP TO PATIENT: _____ ADDRESS: _____

PRIMARY PHONE #: _____ DRIVER'S LICENSE #: _____ STATE: _____

DOB (MM/DD/YYYY) _____ SOCIAL SECURITY #: _____

EMPLOYER: _____ WORK PHONE #: _____

IS THIS PERSON CURRENTLY A PATIENT AT OUR OFFICE? YES - ☐ NO - ☐

PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

DOB (MM/DD/YYYY): _____ SOCIAL SECURITY #: _____

NAME OF EMPLOYER: _____ DATE EMPLOYED: _____

UNION OR LOCAL #: _____ WORK PHONE #: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY: _____ POLICY/ID #: _____ GROUP #: _____

INSURANCE COMPANY ADDRESS: _____ INSURANCE COMPANY PHONE #: _____

SECONDARY DENTAL INSURANCE INFORMATION *(IF APPLICABLE)*:

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

DOB (MM/DD/YYYY): _____ SOCIAL SECURITY #: _____

NAME OF EMPLOYER: _____ DATE EMPLOYED: _____

UNION OR LOCAL #: _____ WORK PHONE #: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY: _____ POLICY/ID #: _____ GROUP #: _____

INSURANCE COMPANY ADDRESS: _____ INSURANCE COMPANY PHONE #: _____

X _____ DATE: _____

SIGNATURE OF PATIENT OR GUARDIAN IF MINOR

PATIENT'S DENTAL HISTORY:

PATIENT'S NAME: _____ DATE OF BIRTH: _____

REASON FOR THIS VISIT: _____

WHEN WAS YOUR LAST DENTAL VISIT: _____ WHAT WAS DONE THEN: _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN: _____

PREVIOUS DENTIST (NAME AND LOCATION): _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN? IF SO, WHEN/WHERE: _____

HOW OFTEN DO YOU BRUSH YOUR TEETH: _____ HOW OFTEN DO YOU FLOSS YOUR TEETH: _____

IS YOUR DRINKING WATER FLUORIDATED: _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES	☐	☐
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW: • CLICKING • PAIN (JOINT, EAR, SIDE OF FACE) • DIFFICULTY IN OPENING OR CLOSING • DIFFICULTY IN CHEWING	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
HAVE YOU EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT…… DATE	_____	
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS?	☐	☐

IF YOU COULD CHANGE ***ANYTHING*** ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

_____

AUTHORIZATION AND RELEASE: I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTICIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X_____ DATE: _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR.

X_____ DATE: _____

DOCTOR'S SIGNATURE

PATIENT MEDICAL HISTORY

PATIENT'S NAME:_____ **EMAIL:**_____ **DATE OF BIRTH**:_____

**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 WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

1. ARE YOU IN GOOD HEALTH……. YES NO
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR… YES NO
3. DATE OF YOUR LAST PHYSICAL EXAM_____
4. PHYSICIAN'S NAME _____
   ADDRESS_____
   PHONE NO. _____
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN…….. YES NO
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS…… YES NO
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE …… YES NO
   IF YES, WHAT MEDICATION(S)…
   _____
8. HAVE YOU HAD ANY ABNORMAL BLEEDING …… YES NO
9. DO YOU BRUISE EASILY ……. YES NO
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION …….. YES NO
11. HAVE YOU HAD A RECENT WEIGHT LOSS ____ ____
12. HAVE YOU EVER TAKEN FEN-PHEN OR REDUX…… YES NO
13. DO YOU USE TOBACCO …… YES NO
14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES …….. YES NO
15. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT… YES NO

WOMEN ONLY:

16. ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT …….. YES NO
17. ARE YOU NURSING …… YES NO
18. ARE YOU TAKING BIRTH CONTROL PILLS YES NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

LOCAL ANESTHETICS LIKE NOVOCAINE…….. YES NO
PENICILLIN OR OTHER ANTIBIOTICS…….. YES NO
SULFA DRUGS…… YES NO
BARBITURATES, SEDATIVES OR SLEEPING PILLS…… YES NO
ASPIRIN…… YES NO
ANY METALS (E.G., NICKEL, MERCURY, ETC.) ……. YES NO
LATEX / RUBBER …… YES NO
Others (PLEASE LIST)
_____

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING?

DIABETES:	YES NO	HYPOGLYCEMIA:	YES NO
RHEUMATIC FEVER:	YES NO	THYROID PROBLEMS:	YES NO
SCARLET FEVER:	YES NO	ALLERGIES:	YES NO
HEART DEFFECT:	YES NO	JOINT REPLACEMENT:	YES NO
HEART MURMUR:	YES NO	KIDNEY TROUBLE:	YES NO
HEART TROUBLE:	YES NO	TUBERCULOSIS:	YES NO
HEART ATTACK:	YES NO	TUMORS:	YES NO
EPILEPSY OR SEIZURES:	YES NO	ANGINA:	YES NO
MENTAL HEALTH CARE:	YES NO	STROKE:	YES NO
PACEMAKER:	YES NO	CHEST PAIN:	YES NO
HEART SURGERY:	YES NO	SINUS TROUBLE:	YES NO
LIVER DISEASE:	YES NO	FEVER BLISTERS:	YES NO
HEPATITIS:	YES NO		
JAUNDICE:	YES NO		
COLD SORES:	YES NO		

SHORTNESS OF BREATH: YES NO
CONGENITAL HEART PROBLEM: YES NO
HIGH/LOW BLOOD PRESSURE: YES NO
EATING DISORDERS: YES NO
SEXUALLY TRANSMITTED DISEASE: YES NO
ASTHMA OR HAY FEVER: YES NO
CHEMICAL DEPENDENCY: YES NO
AIDS OR HIV INFECTION: YES NO
CORTISONE TREATMENT: YES NO
CHEMOTHERAPY(CANCER/LEUKEMIA): YES NO

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X_____ **DATE**_____

SIGNITURE OF PATIENT OR PARENT/GUARDIAN OF A MINOR

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

Signature: **Date of visit:**

Patient/Responsible Party

PLEASE ANSWER "YES" OR "NO" WITH YOUR **INITIALS** TO THE FOLLOWING QUESTIONS:

HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME?	**YES**	**NO**
IF YES, WHEN:		
ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	**YES**	**NO**
DO YOU HAVE A FEVER?	**YES**	**NO**
DO YOU HAVE ANY SHORTNESS OF BREATH?	**YES**	**NO**
DO YOU HAVE A DRY COUGH?	**YES**	**NO**
DO YOU HAVE A RUNNY NOSE?	**YES**	**NO**
DO YOU HAVE A SORE THROAT?	**YES**	**NO**
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	**YES**	**NO**
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	**YES**	**NO**
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	**YES**	**NO**
WITHIN THE LAST 10 DAYS, HAVE YOU TRAVELLED OUTSIDE NEW JERSEY, NEW YORK, CONNECTICUT, PENNSYLVANIA OR DELAWARE?	**YES**	**NO**
IF YES, HAVE YOU BEEN FULLY VACCINATED FOR MORE THAN 2 WEEKS?	**YES**	**NO**

FINANCIAL AGREEMENT
The Office of Michael J. Ilardi, DMD, llc

Thank you for choosing us to provide your dental care. We consider it a privilege to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest, and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of benefits provided you agree to the following:

-You must provide us with an insurance card and all the information necessary to verify your insurance coverage and file your claim.

-Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.

-You are responsible for our fees and not what your insurance company allows or considers "usual, customary, and reasonable" all of which vary from one company to another.

-Although we may estimate your insurance benefit we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. Your estimated portion is expected at time of service.

-All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered services, along with deductibles and co-payments are due at the time of treatment.

PAYMENT POLICY:

-We accept cash, personal checks, debit cards, Visa, Mastercard, and CareCredit.

-After dental insurance has paid its portion, a statement is sent to the mailing address on record, for any remaining balance. Payment is expected within 10 days of the statement date, to avoid finance charges.

-We do not file claims for more than two dental insurance companies.

PATIENTS WITHOUT INSURANCE COVERAGE: We will provide upon request written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for full payment, without any exception. The office will not attempt to collect payment from a parent that is not present in the office at the visit.

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 25 days of monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 2 business days notice are considered broken. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment. You will receive a postcard to remind you of recare appointments a few weeks prior to the appointment and a phone call one day prior as a reminder. Please be aware you cannot leave messages on our machine after hours, any appointment changes need to be made during office hours. A fee of $67.00 will be assessed for broken appointments.

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire, we will provide a copy of your records or radiographs for a nominal duplication fee. Two weeks will be required to accumulate and send such records.

CONSENT AND AUTHORIZATION: I authorize treatment for myself and/or my dependents and agree to pay all related professional fees. Fees not covered by my dental insurance will be paid promptly upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies of Michael J. Ilardi, DMD, llc. Without any reservations, I agree to abide by the policies outlined herein.

Form Completed by:

Name_____Signature_____

Relationship to Patient if not SELF_____

Date_____

Michael J. Ilardi, DMD, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have read and understand this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).