



# DUBLIN DENTAL CARE

Roland Pagniano, DDS, MS & Associates, Inc  
(614) 932-0200

# Patient Registration

First name \_\_\_\_\_ Last name \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ Work phone ( ) \_\_\_\_\_

Sex  Male  Female Marital Status  Single  Married  Separated  Divorced  Widowed

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Driver's license # \_\_\_\_\_ Social security # \_\_\_\_\_

Email \_\_\_\_\_  I would like to receive text/email correspondences

I give Dublin Dental Care permission to leave phone messages, personal information, diagnosis, treatments, billing, at my home/cell numbers

Employer \_\_\_\_\_  Full time  Part time  Retired

Student status  Full time  Part time

How did you hear about us?

Dentist or doctor \_\_\_\_\_  Friend or family \_\_\_\_\_

Other \_\_\_\_\_  Postcard in mail  Facebook  Google

Emergency contact \_\_\_\_\_ Emergency contact phone \_\_\_\_\_

May we release medical records to emergency contact?  Yes  No

Are you the responsible for this account?  Yes  No Name of responsible party: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Name of insured \_\_\_\_\_ Relationship to patient  Self  Spouse  Child  Other

Insured's social security # \_\_\_\_\_ Insured's birth date \_\_\_\_\_ Age \_\_\_\_\_

Employer \_\_\_\_\_

Employer's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance company \_\_\_\_\_ Phone \_\_\_\_\_ Group # \_\_\_\_\_

Insurance company's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Name of insured \_\_\_\_\_ Relationship to patient  Self  Spouse  Child  Other

Insured's social security # \_\_\_\_\_ Insured's birth date \_\_\_\_\_ Age \_\_\_\_\_

Employer \_\_\_\_\_

Employer's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance company \_\_\_\_\_ Phone \_\_\_\_\_ Group # \_\_\_\_\_

Insurance company's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



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# Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. It is imperative for us to know a detailed medical history to best, and safely, provide services to you. Health problems that you may have, or medication that you may be taking, could have an important inter-relationship with the dentistry you will receive. Thank you for answering all of the following questions completely and honestly.

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_

Are you currently under a physician's care?  Yes  No If yes, please explain: \_\_\_\_\_

Physician name \_\_\_\_\_

Physician address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician phone \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Are you currently taking any medications, pills, drugs, herbal/natural/nutritional supplements?  Yes  No

If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No Are you on a special diet?  Yes  No

Do you smoke or use smokeless tobacco?  Yes  No Do you use controlled substances?  Yes  No

Are you allergic to the following?  Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex

Sulfa  Other: \_\_\_\_\_

Women: Are you  Pregnant or trying to get pregnant? Due date: \_\_\_\_\_

Nursing?  Taking oral contraceptives?

Have you or your biological parents experienced any of the following? Circle (S) for self, (M) or maternal, (P) for paternal.

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> S M P AIDS/HIV positive   | <input type="checkbox"/> S M P Artificial Heart Valve | <input type="checkbox"/> S M P Bruise Easily         | <input type="checkbox"/> S M P Convulsions        |
| <input type="checkbox"/> S M P Alzheimer's Disease | <input type="checkbox"/> S M P Artificial Joint       | <input type="checkbox"/> S M P Cancer                | <input type="checkbox"/> S M P Cortisone Medicine |
| <input type="checkbox"/> S M P Anaphylaxis         | <input type="checkbox"/> S M P Asthma                 | <input type="checkbox"/> S M P Chemotherapy          | <input type="checkbox"/> S M P Diabetes           |
| <input type="checkbox"/> S M P Anemia              | <input type="checkbox"/> S M P Blood Disease          | <input type="checkbox"/> S M P Chest Pains           | <input type="checkbox"/> S M P Drug Addiction     |
| <input type="checkbox"/> S M P Angina              | <input type="checkbox"/> S M P Blood Transfusion      | <input type="checkbox"/> S M P Cold Sores / Blisters | <input type="checkbox"/> S M P Easily Winded      |
| <input type="checkbox"/> S M P Arthritis / Gout    | <input type="checkbox"/> S M P Breathing Problems     | <input type="checkbox"/> S M P Congenital Heart Dis. | <input type="checkbox"/> S M P Emphysema          |

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> S M P Epilepsy or Seizures   | <input type="checkbox"/> S M P Hemophilia           | <input type="checkbox"/> S M P Lung Disease        | <input type="checkbox"/> S M P Sickle Cell Disease |
| <input type="checkbox"/> S M P Excessive Bleeding     | <input type="checkbox"/> S M P Hepatitis A          | <input type="checkbox"/> S M P Mitral Valve        | <input type="checkbox"/> S M P Sinus Trouble       |
| <input type="checkbox"/> S M P Excessive Thirst       | <input type="checkbox"/> S M P Hepatitis B or C     | <input type="checkbox"/> S M P Osteoporosis        | <input type="checkbox"/> S M P Spina Bifida        |
| <input type="checkbox"/> S M P Dizziness              | <input type="checkbox"/> S M P High Blood Pressure  | <input type="checkbox"/> S M P Pain in Jaw Joints  | <input type="checkbox"/> S M P Stomach Disease     |
| <input type="checkbox"/> S M P Frequent Cough         | <input type="checkbox"/> S M P Hives or Rash        | <input type="checkbox"/> S M P Parathyroid Disease | <input type="checkbox"/> S M P Stroke              |
| <input type="checkbox"/> S M P Frequent Diarrhea      | <input type="checkbox"/> S M P Hypoglycemia         | <input type="checkbox"/> S M P Psychiatric Care    | <input type="checkbox"/> S M P Swelling of Limbs   |
| <input type="checkbox"/> S M P Frequent Headaches     | <input type="checkbox"/> S M P Human Papillomavirus | <input type="checkbox"/> S M P Prolapse            | <input type="checkbox"/> S M P Thyroid Disease     |
| <input type="checkbox"/> S M P Genital Herpes         | <input type="checkbox"/> S M P Intestinal Disease   | <input type="checkbox"/> S M P Recent Weight Loss  | <input type="checkbox"/> S M P Tonsillitis         |
| <input type="checkbox"/> S M P Glaucoma               | <input type="checkbox"/> S M P Irregular Heartbeat  | <input type="checkbox"/> S M P Renal Dialysis      | <input type="checkbox"/> S M P Tuberculosis        |
| <input type="checkbox"/> S M P Hay Fever              | <input type="checkbox"/> S M P Kidney Problems      | <input type="checkbox"/> S M P Rheumatic Fever     | <input type="checkbox"/> S M P Tumors or Growths   |
| <input type="checkbox"/> S M P Heart Attack / Failure | <input type="checkbox"/> S M P Leukemia             | <input type="checkbox"/> S M P Rheumatism          | <input type="checkbox"/> S M P Ulcers              |
| <input type="checkbox"/> S M P Heart Pacemaker        | <input type="checkbox"/> S M P Liver Disease        | <input type="checkbox"/> S M P Scarlet Fever       | <input type="checkbox"/> S M P Venereal Disease    |
| <input type="checkbox"/> S M P Heart Disease          | <input type="checkbox"/> S M P Low Blood Pressure   | <input type="checkbox"/> S M P Shingles            | <input type="checkbox"/> S M P Yellow Jaundice     |

Do you have, or have you had, any condition or health problem not listed above?  Yes  No

If yes, please explain:

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Have you had any trouble associated with previous dental treatment?  Yes  No If yes, please explain:

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Are you aware of any sores or lumps in your mouth at this time?  Yes  No If yes, please explain:

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How long has it been since your last dental exam? \_\_\_\_\_

Current Medication List (please include all vitamins, herbal / nutritional supplements & OTC products taken routinely)			
MEDICATION NAME	GENERIC NAME	DOSE / FREQUENCY	REASON

When it comes to the dentist, which of these would be of most concern to you? Please select ONE.

- Fear    Time    Budget    No sense of urgency    No trust

Which of the following is most important to you concerning your dental health? Please select ONE.

- Function    Comfort    Cosmetic    Longevity

I, \_\_\_\_\_, have reviewed the information provided. To the best of my knowledge, it is complete and correct.

Print Full Patient Name

Signature - **Circle One: Patient OR Guardian**

Date

OFFICE USE ONLY  
Summary of Patient's Medical Status

**MEDICAL RISK ASSESSMENT**

- ASA I** (healthy individual)  
 **ASA II** (mild systemic disease)  
 **ASA III** (severe disease but not incapacitating)  
 **ASA IV** (incapacitating systemic disease)

**MEDICAL CONSULTATION REQUIRED?**

- NO** (healthy and / or stabilized disease)  
 **YES** (ASA III or IV; cardiac condition; history of recent major disease; recent diagnosis / operation; uncontrollable disease; blood pressure concern; etc.)

**EMERGENCY TREATMENT REQUIRED?**

- NO**  
 **YES** (use space below to explain)

Notes

Doctor's Signature

Date



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# Acknowledgment of Receipt of Notice of Privacy Practices

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\*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT\*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

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



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## Financial Responsibility

### FINANCIAL RESPONSIBILITY FOR PATIENTS

I, \_\_\_\_\_, understand the dentist's billing staff at Dublin Dental Care (Roland Pagniano, DDS, MS and Associates, Inc.) will estimate and file all claims for services rendered to my dental insurance carrier. The dental insurance policy is an agreement between the insurance company and myself, thus, I will not hold Dublin Dental Care responsible for how my insurance company handles its claims or for what benefits are available with my dental insurance carrier.

I acknowledge I am responsible for any balances which may be due to Dublin Dental Care because of:

- Co-insurance or copay amounts
- Yearly deductible amounts
- Balance exceeding my insurance plan's yearly capitation amount
- Non-covered services
- Out-of-network charges
- No insurance coverage or termination of coverage
- Failure to respond to insurance carrier correspondence
- Failure to respond to coordination of benefits inquiry

I understand I will be required to pay for the estimated copayment and deductible. I understand a deposit will be required upon scheduling an appointment for certain procedures. If the copayment is more than originally estimated, I will receive a statement with the adjusted balance. I understand and agree that all monthly statements are due and payable to Dublin Dental Care upon receipt unless prior financial arrangements have been made. I am aware that a billing charge of \$25.00 will be added to my account for any unpaid balances after 30 days.

If I am unable to pay the entire amount, I am responsible to immediately, upon receipt of the statement, contact Dublin Dental Care at (614) 932-0200 to arrange a payment plan using third party financing (such as CareCredit or Springstone). If I am denied credit approval by the third party financing company, I understand I will still be required to immediately pay Dublin Dental Care for the entire amount due.

I understand that failure to pay my entire balance due within 90 days will result in my debt being handed over to a collection agency.

### **BROKEN APPOINTMENT ADDENDUM**

We treat all appointments as reservations and expect those holding appointment reservations to do the same. By signing below, I understand that should I need to reschedule or cancel my reserved appointment, I am responsible for giving Dublin Dental Care at least 48 hours advance notice. Additionally, I understand Dublin Dental Care reserves the right to charge up to \$25 per half hour scheduled when appointment reservations are broken or canceled with less than 48 hours notice. I understand that if I do not confirm or cancel my appointment reservation at least 48 hours in advance, my deposit will be non-refundable. Further, I am aware that Dublin Dental Care reserves the right to dismiss from the practice patients who do not comply with these policies.

I, \_\_\_\_\_, have reviewed the information provided above and acknowledge my approval.  
Print Full Patient Name

Signature - Circle One: Patient OR Guardian

Date