



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 Mitral Valve | <input type="checkbox"/> S M P Sinus Trouble |
| <input type="checkbox"/> S M P Excessive Bleeding | <input type="checkbox"/> S M P Hepatitis A | <input type="checkbox"/> S M P Osteoporosis | <input type="checkbox"/> S M P Spina Bifida |
| <input type="checkbox"/> S M P Excessive Thirst | <input type="checkbox"/> S M P Hepatitis B or C | <input type="checkbox"/> S M P Pain in Jaw Joints | <input type="checkbox"/> S M P Stomach Disease |
| <input type="checkbox"/> S M P Dizziness | <input type="checkbox"/> S M P High Blood Pressure | <input type="checkbox"/> S M P Parathyroid Disease | <input type="checkbox"/> S M P Stroke |
| <input type="checkbox"/> S M P Frequent Cough | <input type="checkbox"/> S M P Hives or Rash | <input type="checkbox"/> S M P Psychiatric Care | <input type="checkbox"/> S M P Swelling of Limbs |
| <input type="checkbox"/> S M P Frequent Diarrhea | <input type="checkbox"/> S M P Hypoglycemia | <input type="checkbox"/> S M P Prolapse | <input type="checkbox"/> S M P Thyroid Disease |
| <input type="checkbox"/> S M P Frequent Headaches | <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 Genital Herpes | <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 Glaucoma | <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 Hay Fever | <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 Attack / Failure | <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 Pacemaker | <input type="checkbox"/> S M P Low Blood Pressure | <input type="checkbox"/> S M P Shingles | <input type="checkbox"/> S M P Yellow Jaundice |
| <input type="checkbox"/> S M P Heart Disease | <input type="checkbox"/> S M P Lung Disease | <input type="checkbox"/> S M P Sickle Cell Disease | |

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

If yes, please explain:

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

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

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

Patient or Guardian Signature

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

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

For Office Use Only

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