RAUZMAN PALLOTTA
GENERAL-AESTHETIC-IMPLANT DENTISTRY

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

PATIENT INFORMATION

DATE:_____ SS#:_____

BIRTHDATE:_____

NAME:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

_____ MALE _____ FEMALE

_____MARRIED _____WIDOW _____SINGLE _____MINOR

_____ SEPARATED _____DIVORCED _____PARTNERED

PATIENT EMPLOYER/SCHOOL: _____

EMPLOYER/SCHOOL ADDRESS:_____

_____

SPOUSE'S NAME:_____

BIRTHDATE:_____

EMPLOYER:_____

ADDRESS:_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

_____

___INTERNET ___FACEBOOK ____SIGN ___ _BROCHURE ____AD

DENTAL INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY: _____

GROUP #: _____ PHONE: _____

SUBSCRIBERS NAME: _____

BIRTHDATE: _____ SS#: _____

RELATIONSHIP TO PATIENT: _____

IS PATIENT COVERED BY ADDITIONAL INSURANCE?_____

INSURANCE COMPANY: _____

GROUP #: _____
PHONE:_____

ASSIGNMENT AND RELEASE

I Certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Drs. Pallotta and Rauzman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits payable to related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print the name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date **Relationship to Patient**

PHONE NUMBERS

HOME: (_____) _____ WORK: (_____) _____ CELL: (_____) _____

EMAIL: _____

SPOUSE'S WORK (_____)_____ BEST TIME AND PLACE TO REACH YOU: _____

INCASE OF EMERGENCY, CONTACT **(Specify someone who does not live in your household.)**

NAME: _____ RELATIONSHIP: _____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____

DENTAL HISTORY

REASON FOR TODAYS VISIT_____
_____
FORMER DENTIST_____
CITY/STATE_____
DATE OF LAST DENTAL VISIT_____
DATE OF LAST DENTAL X-RAYS_____

HAVE YOU HAD ANY OF THE FOLLOWING:

Bad breath	___YES ___NO	Burning sensation on tongue	___YES ___NO	Mouth Breathing	___YES ___NO
Bleeding gums	___YES ___NO	Chew on one side of mouth	___YES ___NO	Mouth pain, brushing	__YES ___NO
Blisters on lips or mouth	___YES ___NO	Cigarette, pipe or cigar smoking	___YES ___NO	Orthodontic treatment	___YES ___NO
		Clicking or popping jaw	___YES ___NO	Pain around ear	___YES ___NO
		Dry mouth	___YES ___NO	Periodontal treatment	___YES ___NO
		Fingernail biting	___YES ___NO	Sensitivity to cold	___YES ___NO
		Food collection between teeth	___YES ___NO	Sensitivity to heat	___YES ___NO
		Foreign objects	___YES ___NO	Sensitivity to sweets	___YES ___NO
		Grinding teeth	___YES ___NO	Sensitivity when biting	___YES ___NO
		Gums swollen or tender	___YES ___NO	Sores or growths in your mouth	___YES ___NO
		Jaw pain or tiredness	___YES ___NO	How often do you loss_____	
		Lip or cheek biting	___YES ___NO	How often do you brush? _____	
		Loose teeth or broken fillings	___YES ___NO		

MEDICAL HISTORY

PHYSICIAN'S NAME: _____ DATE OF LAST VISIT: _____

HAVE YOU EVER TAKEN ANY OF THE GROUP OF DRUGS COLLECTIVELY REFERRED TO AS "FEN-PHEN"? These include combinations of Ioni-

Anemia	___YES ___NO	Diabetes	___YES ___NO	Pacemaker	___YES ___NO
Arthritis, Rheumatism	___YES ___NO	Epilepsy	___YES ___NO	Radiation Treatment	___YES ___NO
Artificial Heart Valves	___YES ___NO	Fainting	___YES ___NO	Respiratory Disease	___YES ___NO
Artificial Joints, Pins, etc.	___YES ___NO	Glaucoma	___YES ___NO	Rheumatic Fever	___YES ___NO
Asthma	___YES ___NO	Headaches	___YES ___NO	Scarlet Fever	___YES ___NO
Back Problems	___YES ___NO	Heart Murmur	___YES ___NO	Shortness of Breath	___YES ___NO
Bleeding Abnormally	___YES ___NO	Heart Problems	___YES ___NO	Skin Rash	___YES ___NO
Blood Disease	___YES ___NO	Hemophilia	___YES ___NO	Stroke	___YES ___NO
Cancer	___YES ___NO	Hepatitis	___YES ___NO	Swelling of feet and ankles	___YES ___NO
Chemical Dependency	___YES ___NO	Hernia Repair	___YES ___NO	Thyroid Disease	____YES ___NO
Chemotherapy	___YES ___NO	High Blood Pressure	___YES ___NO	Tobacco Habit	___YES ___NO
Circulatory Problems	___YES ___NO	HIV/AIDS	___YES ___NO	Tonsillitis	___YES ___NO
Congenital Heart Lesions	___YES ___NO	Jaw Pain	___YES ___NO	Tuberculosis	___YES ___NO
Cortisone Treatments	___YES ___NO	Kidney Disease	___YES ___NO	Ulcer	___YES ___NO
Cough, Persistent	___YES ___NO	Liver Disease	___YES ___NO	Venereal Disease	___YES ___NO
		Mitral Valve Prolapse	___YES ___NO		

List any medications you are currently taking and the correlating diagnosis:

_____
_____
_____
_____

Allergies:

_____
_____
_____
_____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____

Signature of Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Parent, Guardian or Personal Representative — Date

RAUZMAN PALLOTTA
GENERAL-AESTHETIC-IMPLANT DENTISTRY

PATIENT HIPAA AWARENESS

With my permission, Drs. Pallotta & Rauzman may use and disclose protected health information (**PHI**) about me to carry out treatment, payment and healthcare operations (**TPO**). Please refer to the office :Notice of Privacy Practices: for a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Drs. Pallotta & Rauzman reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Drs. Pallotta & Rauzman may call home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Drs. Pallotta & Rauzman may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal or Confidential.

With my permission, the office of Drs. Pallotta & Rauzman may email to my home or other such designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Drs. Pallotta & Rauzman restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing I am allowing Drs. Pallotta & Rauzman to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent.

_____ _____

SIGNATURE of PATIENT or GUARDIAN DATE

_____

PRINT