WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name ______________________ Soc. Sec. # __________
Last Name *First Name* *Initial*

Address ______________________

City __________ State ______ Zip ______ Home Phone __________

Cell Phone __________ Email __________

Sex ❑ M ❑ F Age ______ Birthdate ______ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by __________ Occupation __________

Business Address __________ Business Phone __________

Business Email __________

Whom may we thank for referring you? __________

Notify in case of emergency __________ Home Phone __________

Cell Phone __________ Business Phone __________

Email __________

PRIMARY INSURANCE

Person Responsible for Account ______________________
Last Name *First Name* *Initial*

Relation to Patient __________ Birthdate __________ Soc. Sec. # __________

Address *(if different from patient)* __________ Home Phone __________

City __________ State __________ Zip __________

Cell Phone __________ Email __________

Person Responsible Employed by __________ Occupation __________

Business Address __________ Business Phone __________

Business Email __________

Insurance Company __________ Phone __________

Insurance Email __________

Contract # __________ Group # __________ Subscriber # __________

Name of other dependents under this plan __________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name __________ Relation to Patient __________ Birthdate __________

Address *(if different from patient)* __________ Soc. Sec. # __________

City __________ State ______ Zip ______ Home Phone __________

Cell Phone __________ Email __________

Subscriber Employed by __________ Business Phone __________

Business Email __________

Insurance Company __________ Phone __________

Insurance Email __________

Contract # __________ Group # __________ Subscriber # __________

Name of other dependents under this plan __________

Please complete both sides.

DENTAL HISTORY

What would you like us to do today? ____________ Are you in dental discomfort today? ____________

Former Dentist ____________ Address ____________

Dentist's Email ____________ Phone ____________

Date of last dental care ____________ Date of last x-rays ____________

Check (✓) yes or no if you have had problems with any of the following:

- ❑ Y ❑ N Bad breath
- ❑ Y ❑ N Bleeding gums
- ❑ Y ❑ N Clicking or popping jaw
- ❑ Y ❑ N Food collection between teeth
- ❑ Y ❑ N Grinding or clenching teeth
- ❑ Y ❑ N Loose teeth or broken fillings
- ❑ Y ❑ N Periodontal treatment
- ❑ Y ❑ N Sensitivity to cold
- ❑ Y ❑ N Sensitivity to hot
- ❑ Y ❑ N Sensitivity to sweets
- ❑ Y ❑ N Sensitivity when biting
- ❑ Y ❑ N Sores or growths in mouth

How often do you brush? ____________ Floss? ____________

How do you feel about the appearance of your teeth? ____________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment ____________

MEDICAL HISTORY

Physician's name ____________ Phone ____________

Date of last visit ____________ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe ____________

Are you currently under physician care? ❑ Y ❑ N If yes, describe ____________

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates ____________

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes or no whether you have had any of the following:

- ❑ Y ❑ N AIDS/HIV Positive
- ❑ Y ❑ N Anaphylaxis
- ❑ Y ❑ N Anemia
- ❑ Y ❑ N Arthritis, Rheumatism
- ❑ Y ❑ N Artificial heart valves
- ❑ Y ❑ N Artificial joints
- ❑ Y ❑ N Asthma
- ❑ Y ❑ N Atopic (allergy prone)
- ❑ Y ❑ N Back problems
- ❑ Y ❑ N Blood disease
- ❑ Y ❑ N Cancer
- ❑ Y ❑ N Chemical dependency
- ❑ Y ❑ N Chemotherapy
- ❑ Y ❑ N Circulatory problems
- ❑ Y ❑ N Cortisone treatments
- ❑ Y ❑ N Cough, persistent
- ❑ Y ❑ N Cough up blood
- ❑ Y ❑ N Diabetes
- ❑ Y ❑ N Epilepsy
- ❑ Y ❑ N Fainting
- ❑ Y ❑ N Food allergies
- ❑ Y ❑ N Glaucoma
- ❑ Y ❑ N Headaches
- ❑ Y ❑ N Heart murmur
- ❑ Y ❑ N Heart problems

  Describe ____________
- ❑ Y ❑ N Hemophilia/ Abnormal bleeding
- ❑ Y ❑ N Herpes
- ❑ Y ❑ N Hepatitis
- ❑ Y ❑ N High blood pressure
- ❑ Y ❑ N Jaw pain
- ❑ Y ❑ N Kidney disease or malfunction
- ❑ Y ❑ N Liver disease
- ❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
- ❑ Y ❑ N Mitral valve prolapse
- ❑ Y ❑ N Nervous problems
- ❑ Y ❑ N Pacemaker/ Heart surgery
- ❑ Y ❑ N Psychiatric care
- ❑ Y ❑ N Rapid weight gain or loss
- ❑ Y ❑ N Radiation treatment
- ❑ Y ❑ N Respiratory disease
- ❑ Y ❑ N Rheumatic/Scarlet fever
- ❑ Y ❑ N Shingles
- ❑ Y ❑ N Shortness of breath
- ❑ Y ❑ N Skin rash
- ❑ Y ❑ N Spina Bifida
- ❑ Y ❑ N Stroke
- ❑ Y ❑ N Surgical implant
- ❑ Y ❑ N Swelling of feet or ankles
- ❑ Y ❑ N Thyroid disease or malfunction
- ❑ Y ❑ N Tobacco habit
- ❑ Y ❑ N Tonsillitis
- ❑ Y ❑ N Tuberculosis
- ❑ Y ❑ N Ulcer/Colitis
- ❑ Y ❑ N Venereal disease

Is patient currently taking any medications? If yes, list all:

____

____

Does patient have drug allergies? If yes, list all:

____

____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status,I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____________ Date ____________

Payment is due in full at time of treatment, unless prior arrangements have been approved.

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Welcome Packet
Dr. Andrew V. Mastronardi, DMD
Bisphosphonate Release Form

**** Are you taking now, or have you ever taken any of the following bisphosphonate
medications for osteoporosis or post cancer treatment? (please circle)

Evista	YES	NO
Fosomax	YES	NO
Boniva	YES	NO
Didronel	YES	NO
Aredia	YES	NO
Actonel	YES	NO
Zometa	YES	NO
Reclast	YES	NO

Signature____
Date____________________

Andrew V. Mastronardi, DMD, PC
Our Financial Policy

Thank you for choosing Dr. Andrew Mastronardi as your dental provider and please know we are committed to the successful dental treatment for you and your family. You are being asked to read and sign our Financial Policy prior to your treatment so we may better understand what's expected of each other. Parents and/or responsible parties for children will sign prior to the children's treatment. Payment of your bill is considered part of your treatment. If requested, we will supply you with copies of all signed forms.

All patients must fully complete personal and health information forms prior to seeing the doctor and/or hygienist. This is imperative so we may better treat you as a whole patient with respect to your overall health. Periodically we will ask you to complete personal and medical update forms.

For patients who have insurance with assignment of benefits: For treatment procedures where the fee is $350.00 or more, we will require payment of at least 50% at the first appointment as these procedures are usually covered by insurance at 50%. When no insurance is involved, if the procedure is completed in one visit, payment in full is due at that appointment regardless of the dollar amount. If the procedure is completed in 2 or more visits, 50% is due at the first appointment and the remainder is to be paid in full prior to being seated at the final appointment.

Where there is insurance involvement, please be advised that there may be deductibles and/or co-insurance to be paid at the time of service. We will determine these amounts based on the information we receive from your insurance company.

In the event your insurance company does not resolve a claim within 60 days of treatment (whether primary insurance or secondary insurance) regardless of reason, we will require the balance to be paid in full from you at that time and will request the insurance company reimburse you directly.

Each insurance policy is different and has a unique set of requirements. If your insurance requires anything special from our office you are responsible for supplying us that information. If you are not certain of any special requirements, please bring in your booklet and our financial coordinator will be happy to help.

We reserve the right to assess a 1.50% monthly finance charge on balances over 60 days past due regardless of status of insurance, if any.

Persons responsible for payment for dependent children but do not accompany them (ex: child gets dropped off and picked up, high school or college age dependent drives themselves, another adult brings the child in) must make payment arrangements prior to the appointment. Ex: credit/debit card on file, have the dependent child or other adult bring in a payment.

We respect your time and commitment to your oral health and, in return, request that you respect our time and commitment to you as well by keeping the appointment time we have reserved especially for you. If you fail to notify us of a cancelled appointment without a minimal 24 hour notice we reserve the right to assess a broken appointment fee of at least $40.00 per broken appointment.

_______________________________________ _______________________________

Signature of Responsible Party Date

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Printed Name of Responsible Party