WELCOME

1 ABOUT YOU

Today's Date: ____/____/____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext: _____

Cell Phone #: (_____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

2 INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____) _____

Payment method: ❑ Cash ❑ Check

_____ ____/____

❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

4 EMERGENCY CONTACT

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____) _____

CONTINUE ON BACK

5 DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation Are you in pain? ❑ No ❑ Yes How Long?_____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw	❑ Lost/Broken Filling(s)	❑ Stained teeth	❑ Broken/Chipped tooth
❑ Blisters/Sores in or around the mouth	❑ Teeth grinding	❑ Locking Jaw	❑ Sensitive tooth, teeth or gums
❑ Red, swollen or bleeding gums	❑ Ringing in Ears	❑ Bad breath	❑ Active Decay/Cavity(ies)

❑ Other:_____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know Have you ever been treated for Gum Disease? ❑ Y ❑ N

Previous Dentist:_____ (_____) _____
Name Address Phone#

Last Dental exam:___/___/___ Last Dental X-rays:___/___/___ Last Dental Cleaning:___/___/___

Have you had problems with previous dental treatment? If so, explain:_____

Times a day you brush?____ Times a week you floss?____ Type of tooth brush bristles? ❑ Soft ❑ Medium ❑ Hard

Rate your Smile from (EXCELLENT=10) 1-10:_____ Would you like whiter teeth? ❑Y ❑N Have you had orthodontic treatment? ❑Y ❑N

Things you would change about your smile?_____

6 MEDICAL HISTORY & INFORMATION

What medications are you taking? ❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants

❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis ❑ **Vitamins/Supplements** _____

❑ Other(s), please list:_____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	Y N Heart Attack/Stroke	Y N Heart Surg./Pacemaker	Y N Heart Disease/Angina	Y N Shingles
Y N Lung Disease	Y N Thyroid Problems	Y N Congenital Heart Defect	Y N Cancer/Tumor(s)/Growth(s)	Y N Hepatitis
Y N Liver Problems	Y N Seizures/Epilepsy	Y N Artificial Heart Valves	Y N Chemotherapy/Radiation	Y N Glaucoma
Y N Blood Disease	Y N Venereal Disease	Y N Mitral Valve Prolapse	Y N X-ray or Cobalt Treatment	Y N Arthritis/Gout
Y N Kidney Problems	Y N Cosmetic Surgery	Y N G.I. Problems/Ulcers	Y N Frequent Thirst/Urination	Y N Leukemia
Y N Scarlet Fever	Y N Dizziness/Fainting	Y N Emphysema/Asthma	Y N Bleeding Problems/Anemia	Y N Chest Pains
Y N Tuberculosis TB	Y N Cold/Fever Blisters	Y N Diabetes/Hypoglycemia	Y N High/Low Blood Pressure	Y N Bruise Easily
Y N HIV+/AIDS/ARC	Y N Blood Transfusion	Y N Psychiatric Problems	Y N Artificial Bones/Joints/Implants	Y N Allergies
Y N Rheumatic Fever	Y N Alcohol/Drug Abuse	Y N Back/Neck Problems	Y N Severe/Frequent Headaches	Y N Nervousness
Y N Sinus Problems	Y N Eating Disorder	Y N Respiratory Problems	Y N Jaw Problems TMJ/TMD	Y N Sleep Apnea

Please list any other surgeries or medical conditions you have or ever had:_____

_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Codeine

❑ Dental Anesthetics ❑ Foods:_____ ❑ Others:_____

Do you use tobacco? ❑ No ❑ Yes/How used?_____ How much?_____ How long?_____

Please rate your general health from 1-10:_____ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No Are you taking hormonal replacement? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long?_____ Are you nursing? ❑ Y ❑ N How many children have you had?_____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ Initials **I acknowledge that I have received a copy of the Summary of Privacy Notice.**

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials ___/___/___ Date
Comments

Initials ___/___/___ Date
Comments

Initials ___/___/___ Date
Comments

First Impression Forms, Inc. 1-800-99FORMS FORM # 7DHA1 Copyright © 2011

Patient Communication Permission

Patient Name _____ ID#_____ DOB_____

As a patient in our office, from time to time we may need to communicate with you when you are not available. To preserve your privacy, we would like for you to indicate your preferred method for us to communicate dental information to you. Examples of dental information include your appointment reminders, pre-med reminders, and dental lab cases.

Without specific permission we will not release any of your dental information to another person. In some cases you may wish for another person to have access to your dental information. Please identify those individual(s) and their relationship to you. (i.e. spouse, parent, son, daughter, etc.)

Name	Relationship
_____	_____
_____	_____

In the event that no one is available to answer your phone, we need your permission to leave certain types of dental information on an answering machine, voicemail, or email. Please indicate you preference by checking one or more of the spaces below.

Please contact me with dental information by:
____ leaving a message on an answering machine
____ leaving a voicemail on my cell phone
____ texting my cell phone
____ sending me an email

I give permission to leave the following information pertaining to me on the following phone numbers &/or email address:

Home #_____ Cell# _____
Work# _____ Email _____

Appointment reminders	_____ yes	_____ no
Pre-Med reminders	_____ yes	_____ no
Dental Lab case	_____ yes	_____ no
Any other type of dental communication	_____ yes	_____ no

I assume responsibility to inform the department of changes in my phone number(s)/email and my preferences.

Signature _____ Date_____

ADA Dental Claim Form

Sign & date only

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐ M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee 0

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

Rinaldi Family Dentistry
226 Broadway

Bangor PA 18013

49. NPI 1346781424
50. License Number 036961
51. SSN or TIN 810748348
52. Phone Number (610) 588 - 5151
52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) — Date

54. NPI 1003126392
55. License Number 036961
56. Address, City, State, Zip Code

226 Broadway
Bangor PA 18013

56A. Provider Specialty Code
57. Phone Number ( ) -
58. Additional Provider ID

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To Reorder call 1-800-947-4746

Rinaldi Family Dentistry, LLC
226 Broadway Bangor, PA 18013
610-588-5151

Financial Policy

Thank you for choosing Rinaldi Family Dentistry for your dental needs. Our primary mission is to deliver comprehensive, comfortable, and affordable treatment to each of our patients. Payment for service is expected at the time that service is provided. Cash, personal check, Care Credit, and credit card (Visa, MasterCard, American Express, and Discover) payments are accepted. For larger, more comprehensive treatment plans a 25% deposit is required to secure your initial treatment appointment.

If you have dental insurance:

As a courtesy, we will file your claim for you. We will accept direct payment from most insurance companies. Our fees may be different from the schedule of "allowable" fees from your insurance company. If we participate with your insurance company, we will adjust the fees accordingly. If we do not participate with your insurance company, the balance due for treatment will be your responsibility. All services will be charged directly for the patient and the patient is ultimately responsible for the account regardless of insurance coverage.

Please choose how you will be paying for today's service:

___ Cash
___ Check
___ Credit Card
___ Care Credit

I understand and agree that all services rendered to my dependents and I will be charged directly to me. I further understand that I am personally responsible for payment. If I terminate treatment, all fees for treatment completed will be immediately due and payable. If the fees for professional services are not paid in accordance with this contract, reasonable attorney fees, finance charges and disbursements will be included in the computation of the amount due. Finance charges are applied at the rate of 1.5% per month, $25 delinquent fees will be added to any account date past 60 days of service. Further, if your account is in default and turned over for collections, all collection fees will be added to the amount owed.

_____	_____	_____
Print Name	Signature	Date

Rinaldi Family Dentistry
226 Broadway
Bangor, PA 18013
610-588-5151

Records Release Request

Date: _____

To: _____
_____
_____
_____

On behalf of, _____, _____, I authorize the release of dental x-rays to:
patient name printed DOB

Rinaldi Family Dentistry, LLC
226 Broadway
Bangor, PA 18013

Please email digital x-rays to : rinaldifamilydentistry@gmail.com

_____
Patient Name

_____
Signature (patient, parent/guardian)