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

Primary Insurance Information

Please turn this sheet in as soon as you complete it and we will get started on your complementary benefits check. Thanks!

Name of Insured: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security #:_____ Insured Birth Date: _____ Age: _____

Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Phone: _____ Group #: _____

Insurance Company Address: _____ City: _____ State:_____ Zip: _____

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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

☐ Kayla from WCOL ☐ Postcard in mail ☐ Facebook ☐ Google ☐ Other

Emergency contact Emergency contact phone

May we release medical/dental records to emergency contact? ☐ Yes ☐ No

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

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.

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

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

_____

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

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

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

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

Dublin Dental Care may share dental information with: _____

_____
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 the respect of at least two businuess days' notice. Additionally, I understand Dublin Dental Care reserves the right to charge a $50 fee for those who have multiple broken appointments, and the right to dismiss me as a patient from the practice when appointment reservations are broken or canceled with less than 24 hours' notice.

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

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