David A. Lipani, DMD LLC

We are pleased you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? ___________________

Patient Information

Date_________________ Patient's Name ____
Last First Middle

Address ____
Street Unit# City State Zip

Home Ph.# (_____) ________________ Work Ph.# (_____)_________________ Cell Ph.# (_____)____________________

Soc. Sec. # ______-_______-________ Drivers. Lic. # ____________________ E-Mail ___________________________

Birthdate ____/____/____ Sex M F If patient is a minor, give parent's or guardian's name ___________________________

Emergency Contact ____ Ph. # (_____) ___________________________________

Responsible Party Information

Name____
Last First Middle Marital Status

Soc. Sec. #______-______-_______ Birthdate ____/____/____ Relationship to Patient_______________________________

Residence ____
Street Unit.# City State Zip

Mailing Address ____
Street City State Zip

Home Ph. # (____) __________ Work Ph. # (____) ___________ Cell Ph. # (____) ____________ Fax (____) ___________

Spouse's Name ____ Relationship to Patient ____________________________

Soc. Sec. #______-______-________ Birthdate_____/____/____ Work Ph.# (____)________________________________

Employer ___________________________ Occupation___________________________ No. Years Employed__________________

Employer Address____

Insurance Information

Primary Insurance Company_______________________ Ph.# (____)___________________ Group # _____________________

Insured's Name _________________________________ Insured's Soc. Sec.# __ ___-____-______ Insured's DOB ___/___/____

Is the policy connected with your union? YES NO Name of Union_________________________ Local #_________________

Do you have dual coverage? YES NO If yes: Please complete the following secondary insurance information:

Secondary Insurance Company_____________________ Ph.# (____)___________________ Group# _______________________

Insured's Name _________________________________ Insured's Soc. Sec #_____-_____-______ Insured's DOB ___/___/____

Dental Information

Do your gums bleed when you brush? YES NO

Are your teeth sensitive to heat or cold? YES NO Pressure? YES NO Sweets? YES NO

Do you grind or clench your teeth? YES NO

Do you have any fear of dental work? YES NO

Date of last dental visit ___________ What was done at that time? ____

Former Dentist Name____ City _______________________

How would you describe your current dental problem? ____

____

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

Medical Information

1. Are you having pain or discomfort at this time? ________ YES NO
2. Have you been a patient in the hospital during the last two years? ________ YES NO
3. Are you now taking any medications or drugs? ________ YES NO
   If yes, please list: ________
4. Have you ever taken FOSOMAX or any bisphosphonate medication ? ________ YES NO
5. Have you taken any medications or drugs during the last two years? ________ YES NO
6. Have you been under the care of a medical doctor during the last five years? ________ YES NO
   Physician's Name ________ Ph.# ________
   Address ________
7. Are you allergic to any medications or anesthetics? ________ YES NO

8. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Heart Failure	YES	NO	Artificial joints (hip, knee, etc.)	YES	NO	Hepatitis	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	If yes which strain? A B C		
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Developmentally Disabled	YES	NO	Tumors	YES	NO
Allergy to Latex	YES	NO	Allergy to Metal (Jewelery,etc.)	YES	NO	Osteoporosis	YES	NO

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ________ YES NO
10. Do your ankles swell during the day? ________ YES NO
11. Have you lost or gained more than ten pounds in the last year? ________ YES NO
12. Did you ever wake up from sleep and feel short of breath? ________ YES NO
13. Are you on a special diet? ________ YES NO
14. Do you have or have you had any disease, condition, or problem not listed? ________ YES NO
    If yes, please list: ________

FOR WOMEN ONLY:
Are you pregnant? YES NO What month? ____ Are you nursing? YES NO Are you taking birth control pills? YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature ________ Date ________

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) ________. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1- 1.5 finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that it is my responsibility to advise this office of any changes in the information obtained on this form.
5. I authorize the use of my social security number to file my dental claim.

Patient Signature ________ Date ________

Parent or Responsible Party ____________________________________ Relationship to Patient _________________

Financial Policy

We are pleased you have chosen us to address your dental concerns. Our primary goal is to restore, preserve, and protect your dental health.

If you have a dental benefit plan, we will be happy to assist in filing your claim for service. You as the insured, however, are responsible for understanding your plan parameters and coverage. Most benefit plans offer only partial coverage and have a yearly maximum. Payment of fees is ultimately the responsibility of the patient

Payment is due when services are rendered. In addition to cash and personal checks, we do accept credit cards for your convenience. If a payment plan is needed, we offer CareCredit® as an extended payment option.

Patients with accounts in arrears may be referred to a collection agency, and will be responsible for any collection agency fees, and or court costs in addition to the outstanding balance.

Please sign below to indicate that you understand and agree to the above stated policy.

Responsible Party's Signature ____

Please Print Your Name ____

Guarantor For ____

Date ________________________________

Acknowledgement of Receipt of Notice of Privacy Practices

This form is available on our website or at our front desk for your review. You may refuse to sign this acknowledgement

I, (*please print your name*)__________________________________ have received a copy of this office's Notice of Privacy Practices

Signature__________________________________ Date__________________________

---For office Use Only---

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could no be obtained because:

Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgement ☐

An emergency situation prevented us from obtaining acknowledgement ☐ Other ☐ ____

Authorization for Signature on File

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance claims. 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 regardless of insurance coverage.

Please Print Your Name ___________________________Signature ____________________________________

Date ____________________________________