Bufano & Bufano DDS, PA

Confidential

PATIENT REGISTRATION FORM

Welcome to our healthcare team! Please fill out this information completely in ink. If you have any questions or concerns please do not hesitate to ask for assistance-we will be happy to help.

Today's Date: ____________________

General Information

Name ____________________ ____________________ ____
Last *First* *M.I.*

Preferred to be called ____________________

Birth Date ____________________

Home Phone (____) ____ - ______

Cell Phone (____) ____ - ______

Email Address ____________________@____________

Address ____________________

City ____________ State ________ Zip ____________

Social Security # ____ - ____ - ______

Driver's License # ____________ State ________

Employer ____________________

Occupation ____________________

Work Phone (____) ____ - ______

Individual Status: *(please check one)*

☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Name of Spouse/Guardian

____________________ ____________________ ____
Last *First* *M.I.*

Social Security # ____ - ____ - ______

Spouse/Guardian's Employer ____________________

Work Phone (____) ____ - ______

Emergency Contact Name

Emergency Phone (____) ____ - ______

Whom May We Thank for Referring You?

Name ____________________

☐ Website ☐ Search Engine ☐ Mailer ☐ Yellow Pages

Insurance

Our policy allows 6 weeks for insurance to pay before the patient becomes responsible for the balance. One claim form per year is required.

Name of Person Responsible for This Account?

____________________ ____________________ ____
Last *First* *M.I.*

Relationship to Patient ____________________

Dental Insurance Company ____________________

Phone (____) ____ - ______

Address ____________________

City ____________ State ________ Zip ____________

Policy/Group # ____________________

ID or Social Security # of Insured ____________________

Date of Birth of Insured ____________________

I authorize provider, insurer or other organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the plan administrator or its authorized agent for the purpose of determining benefits payable.

I authorize payment to Bufano & Bufano, D.D.S., P.A. of the dental benefits otherwise payable to me.

Signature of Patient or Parent if Minor

____

Date

____

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Name ______________________________

Health History

Birthdate ____________________

Correct answers to the following questionnaire will allow us to treat you on a more individual basis, providing the care appropriate for your particular needs.

Medical

Physician ______________________________

Office Phone (_____) _____ - ________

Date of Last Exam ____________________

	Yes	No
Do you require antibiotics before dental treatment?	☐	☐
Are you presently under the care of a physician?	☐	☐

If so, why? ______________________________

	Yes	No
Are you presently taking any medications?	☐	☐

If so, please list: ______________________________

	Yes	No
Do you presently have any condition, disease or syndrome?	☐	☐

If yes, please specify: ______________________________

Are you allergic to or have you reacted adversely to any of the following: *(please check all that apply)*

☐ Aspirin ☐ Local Anesthetic ☐ Erythromycin ☐ Penicillin
☐ Latex ☐ Nitrous Oxide Other: ____________________

	Yes	No
Do You Wear Contact Lenses?	☐	☐
Do you occasionally take recreational drugs?	☐	☐

If so, how often: ____________________

	Yes	No
Have you or are you presently taking bisphosphonates? (Actonel, Boniva, Fosamax, Skelid, Didronel, Aredia, Zometa, Bonefos)	☐	☐
Do you smoke or use tobacco products?	☐	☐

If so, how much per day: ____________________

	Yes	No
Do you drink alcoholic beverages?	☐	☐

If so, how much per day/week: ____________________

	Yes	No
(Women) Are you pregnant now?	☐	☐

If so, how many months: _____

	Yes	No
(Women) Are you nursing?	☐	☐
Are your immunizations current and up to date?	☐	☐

Do you have or have you had any of the following?
(please check all that apply)

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artifical Heart Valves
- ☐ Artifical Joints
- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Blood Disease
- ☐ Cancer Treatment
- ☐ Cardiac Pacemaker
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chronic Cough
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever Blisters
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Hepatitis
- ☐ Hemophilia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Low Blood Pressure
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Organ Transplant
- ☐ Nervousness
- ☐ Fen-Phen
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumor or Growth in Head or Neck
- ☐ Venereal disease
- ☐ Weight Loss, Unexplained

Dental

Previous Dentist ______________________________

Phone (_____) _____ - ________

How long since your last dental exam? ____________________

How long since your last dental x-rays? ____________________

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Do you regularly use floss?	☐	☐
Do your gums bleed when flossing or brushing?	☐	☐
Are any of your teeth sensitive to hot, cold, sweets or pressure?	☐	☐
Are you unhappy with the appearance of your teeth?	☐	☐

Name ______________________________

Health History - *Continued*

	Yes	No
Are you aware of grinding or clenching your teeth?	☐	☐
Do you have discolored teeth that bother you?	☐	☐
Do any of your teeth hurt?	☐	☐
Does food get stuck between your teeth?	☐	☐
Do you have sores or lumps in or near your mouth?	☐	☐

Minor/Child Consent

I, being the parent or guardian of ____________________ do hereby request and authorize Drs. Bufano & Bufano and their dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature of Parent/Guardian

____

Date

____

Financial Agreement

I acknowledge that payment in full is due at the time of treatment, unless arrangements are made prior to receiving dental treatment. Patients with insurance are required to pay any amount not anticipated to be covered by the insurance at the time of service. Parents/Guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all fees not covered by the insurance. I also agree to pay within 10 days after receipt of insurance payments any amount not paid by the insurance company. In the case of default on payment of this account, I agree to pay collection costs, reasonable attorney fees and any additional costs incurred in attempting to collect on this account or any future outstanding account balances.

Initial ________

Broken Appointment Policy

When appointments are made they are for your convenience and we expect them to be kept. If you fail to keep an appointment or show up late, you are depriving someone else of this time. It is your responsibility to keep track of your child's appointment. If you are unable to keep an appointment, please notify us at least 24 hours in advance. Failure to do so may result in dismissal from our office. After two (2) broken appointments including less than 24 hour notifications or 'no showing' to your appointed time will result in dismissal from the office.

Initial ________

Medicaid Card Policy

It is the patient's or the parent's responsibility to bring a valid Medicaid card to each appointment. Without a valid card you will not be seen for your scheduled appointment and will be considered a broken appointment. On busy office days, the front office will not be able to verify Medicaid without your card. Please present your card when you arrive to your scheduled appointment.

Initial ________

Signature of Patient/Parent/Guardian

____

Date

____

This information has been checked and reviewed by:

Dental Office Associate

____

Request and Consent to Dental Treatment

1. I request and authorize Dr. Eric Bufano and/or Dr. Lisa Bufano and/or assistants of his/her choice to perform the procedures outlined in the proposed treatment plan set forth by Dr. Eric Bufano and/or Dr. Lisa Bufano and myself.
2. I further request and authorize the taking of oral dental X-rays and the use of such anesthetics as may be considered necessary and/or advisable by the doctor responsible for my/the patient's treatment.
3. I have had explained to me, and I had sufficient opportunity to discuss my/the patient's dental condition/problem(s), the planned procedures and treatment and the benefits to be reasonably expected from this treatment, compared with alternative approaches and/or no treatment.
4. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include, but are not limited to, the possibility of pain or discomfort during and following treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a tooth or portion thereof into the sinus (a normal cavity situated above the upper teeth) or other anatomic location requiring additional surgery to close the opening or recover the tooth structure, temporary or permanent numbness, and allergic reactions.
5. Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is usually transient but, on occasion, may be permanent), reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure.
6. The risks of complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness, lack of awareness and coordination, nausea, allergic reactions, etc. (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs.) [It is not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may prescribe.] [Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other/additional contraceptive measures be taken during the administration of antibiotics.]
7. I understand that during the course of my/the patient's dental treatment something unexpected may arise that may necessitate procedures in an addition to or different from those planned. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made concerning the results of the treatment that I/the patient will receive.
8. All of my questions have been answered to my satisfaction, and I consent to the treatment and procedures prescribed for me/the patient.
9. I understand that I may revoke this consent to treatment at anytime and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
10. I confirm that I have read this form, or it was read to me that all blanks were filled in and all inapplicable paragraphs, if any, were crossed out before I signed.

Patient/Parent/Guardian Signature: ______________________ ***Date:*** ______________

I certify that I have explained the nature, purpose, benefits, the usual and most frequent risks and hazards of, and alternatives to, the treatment and procedures for the patient. I have offered to answer any questions and have fully answered such questions. I believe that patient/relative/guardian understands what I have explained and has consented to the proposal treatment and procedures.

Doctor Signature: ______________________ ***Date:*** ______________

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: ____

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

________________________ ________________________

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  ____
- ☐ Other: ____

  ____

Prepared By ____

________________________ ________________________

Signature Date

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