Patient Information

Please take a few minutes to help us update our records.....Thank you.

Name ______________________________ **Date:** ____________
Address: ________________________ **DOB:** ____________
City: ______________**Zip Code:** ______ **Phone:** ____________
Cell: ________ **Marital Status:** ___
Email Address: ______________________**SS#**_____-____-______
Physician: ________________**Phone:** ______________________
Address: ____
Emergency Contact: _________________ **Phone:** ______________
Pharmacy: _______________________ **Phone:** ______________

Primary Dental Insurance :

Carrier: ______________
Policy Number: __________
Claims Address: __________
Policy Holder: __________
DOB: ______________
SS. #: ______________
Employer: ______________
Address: ______________
Phone: ________________

Secondary Dental Insurance :

Carrier: ______________
Policy Number: __________
Claims Address: __________
Policy Holder: __________
DOB: ______________
SS.#: ______________
Employer: ______________
Address: ______________
Phone: ______________

Medical Insurance:

Carrier: ______________
Policy Number: __________
Claims Address: __________
Policy Holder: __________
DOB: ______________
SS. #: ______________

Employer: __________________
Address: __________________
Phone: ____________________

Responsible Party: ________________ **Relationship:** _________
Employer: ______________________
Date of Birth: ____________ **S.S. Number:** ___________
Address: ________ **City:** ________ **State:** _______ **Zip:** ______

The above information is true and accurate to the best of my knowledge. I understand that I am responsible for all patient charges and authorize the release of information, including x-rays, to my benefits otherwise payable to me directly to

Michael S. LaMastra, D.D.S.

Patient Signature: ________________ **Date:** ______________

MEDICAL HISTORY and CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Allergies
Acrylics Y N
Anaphalaxis Y N
Latex Y N
Local Anesthetics Y N
Penicillin Y N
Metal Y N
Sulpha Y N
Other Y N
List otherknown allergies:

____
____
____
____
____

Cardiovascular
Artificial Heart Valve YN
Coronary Artery Disease Y N
Chest Pain or Angina Y N
Congestive Heart Failure Y N
Heart Attack Y N
Heart Murmur Y N
High Blood Pressure Y N
High Cholesterol Y N
Irregular Heart Beat Y N
Low Blood Pressure Y N
Mitral Valve Prolapse Y N
Pacemaker Y N
Tachycardia Y N

Endocrine
Diabetes Y N
Gout Y N
Hormonal Change Y N
Thyroid problems Y N

Eyes, Ears, Nose and Throat
Change in Hearing Y N
Change in Vision Y N
Dysphagia Y N
Ear Pain Y N
Glaucoma Y N
Hay Fever Y N
Nasal Obstruction Y N
Nose Bleeding Y N
Sinus Problems Y N
Tonsillectomy Y N
Tinnitus Y N

Gastrointestinal
Acid Reflux Y N
GERD Y N
Soft or Special Diet Y N
Ulcers Y N

Genitourinary
Frequent Urination Y N
Kidney disease Y N
Nocturia Y N

General
Current weight: ________lbs
Height: _______ ft ______in
Cancer Y N
Fatigue/Tired Y N
General Weakness Y N
Headaches Y N
HIV/AIDS Y N
Knee/hip replacement Y N
Liver problems Y N
Recent Trauma or Injury Y N
Rheumatic Fever Y N
Radiation Treatment Y N
Weight Change Y N

Hematological
Bleeding problems Y N
Hepatitis Y N

Oral
Bleeding gums Y N
Dry mouth Y N
Jaw problems (TMJ)? Y N
Clicking? Y N
Pain? Y N
Difficulty swallowing? Y N
Difficultychewing? Y N
Orthodontics/Invisalign Y N
Periodontal Disease Y N
Teeth clenching Y N
Teeth grinding Y N
Tooth pain Y N
Wisdom teeth extraction Y N
Do you wear removable teeth? Y N
Do you take or need antibiotics before dental procedures? Y N

Musculoskeletal
Back Pain Y N
Fibromyalgia Y N
Joint Pain Y N

Neurological
Alzheimer's Disease Y N
Dizziness Y N
Fainting Y N
Memory Loss Y N
Multiple Sclerosis (MS) Y N
Muscle Weakness Y N
Seizures Y N
Stroke Y N
Tingling/Numbness Y N
Trigeminal Neuralgia Y N
Tremor Y N

Psychiatric
ADD/ADHD Y N
Anxiety Y N
Chemical Dependency Y N
Depression Y N
Eating disorders Y N
Excessive Stress Y N
Memory problems Y N

Respiratory
Asthma Y N
Bronchitis Y N
Breathing problems Y N
Chest Pressure Y N
Congestion Y N
Dyspnea(shortness of breath) Y N
Emphysema Y N
Orthopnea Y N
Pneumonia Y N
Pulmonary Embolism Y N
Tuberculosis Y N

Sleep
Daytime Sleepiness Y N
Morning headaches Y N
Obstructive Sleep Apnea Y N
Do you use a CPAP? Y N
How often? ________________
Has anyone told you that yousnore? Y N

Social History
Do you smoke? N Y ___ packs a day
Do you use smokeless tobacco? Y N
Do you consume alcoholic beverages?
_____Drinks per day/week/month

Do you use recreational drugs?Y N

CONFIDENTIAL

MEDICAL HISTORY and CONSENT

List any medications you are taking:

Medication	Dosage/Freq.	Prescriber	Reason
1.			
2.			
3.			
4.			
5.			
6.			

List any surgeries or hospitalizations you have had:

Date(year)	Surgery	Surgeon	Reason

List and detail any medical condition or history not listed above:

____

____

____

____

Primary Physician's Name: ____________________ Physician's phone #: ____________

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Maple Dental to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Maple Dental perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Maple Dental choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Maple Dental. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous tomy/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1 1/2% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Maple Dental and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (adult):

Name of Patient __________________ __________________ **Date** __________

Signature of Patient

Consent (for a minor child):

Name of Parent/Guardian __________________ __________________ **Date** __________

Signature of Parent/Guardian

Notice of Privacy Practices (below)

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

__________________ **Date** __________

Signature of Patient

CONFIDENTIAL

MICHAEL S. LAMASTRA, D.D.S.
MAPLE DENTAL
4243 MAPLE ROAD
AMHERST, NEW YORK 14226
(716) 833-4637

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: ______________________________ Date of Birth: ______________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ______________________________ Date: ______________

Relationship to patient (if signed by a personal representative of patient): ______________

GHI/Local 55 Patients
Procedure Waiver

Provider Name: ______________________________

Patient Name: ______________________________

Certificate No: ______________________________

- **Composite Restorations (posterior only) – D2391, D2394**
- **Crowns – D2720, D2722, D2740, D2750, D2752, D2780, D2782, D2790, D2792, D2794 and D2933.**
- **Crowns over Implants – D6058, D6067**
- **Pontics – D6210, D6212, D6214, D6240, D6242, D6245, D6250 and D6252**
- **Abutment Crowns – D6720, D6722, D6750, D6752, D2780, D2782, D6790, D6792 and D6794**
- **Onlays – D2452, D2544, D2642, D2644, D2662, D2664, D6608, D6615**

The patient and/or patient's family has been educated as to all treatment options available through our office.

The charge for the procedure is based upon our normal fee for the procedure.

The patient and/or patient's family is responsible for any difference between our normal fee and GHI/Local 55's benefit reimbursement.

This office will charge for above procedures above and beyond GHI and Local 55's fees.

____
Signature of Financially responsible party

Relationship to patient: ____________________ Date: ________________

Example: Crowns - $400.00 (Ins. Payment) plus $150.00 for materials.
Fillings - $37.00 (Ins. Payment one surface) plus $25.00 for comp

Dental History

How long has it been since you have been to the dentist?

___

What was done at that appointment?

___

How long has it been since you had a full mouth x-ray or a panoramic x-ray?

___

Why did you leave your old dentist?

___

Who may we thank for referring you to our office?

___

What is your reason for seeking treatment today?

___

If you could change anything about your smile what would it be? (Color, shape of the teeth, straighter, etc.)?

___

FINANCIAL POLICY

We would like to thank you for selecting our office for your dental care. Traditionally, doctors have been very uncomfortable discussing financial matters with their patients. We have chosen to inform you of our financial policies in writing in an attempt to avoid this situation.

1. We will try to inform you of all services to be rendered and their estimated cost. Please ask the doctor or staff if you have any questions.

2. We expect payment in full at each visit, unless PRIOR arrangements have been made with our business office. We accept cash, personal check, and major credit cards. Please inform us before starting treatment if you need a payment plan so that arrangements can be made.

3. We will submit all charges to your insurance company, as a courtesy, if you have dental coverage. We will try to estimate what your portion will be at each visit. We expect your portion to be paid at the time of service instead of waiting until the insurance carrier has paid. Please note: Insurance policies and contracts are between the patient and the insurance company. It is your responsibility to familiarize yourself with your policy. You are fully liable for all charges on your account even if you have dental coverage.

4. You will be assessed a billing fee of $2.50 per month on outstanding balances beyond 30 days from the date of service (except for orthodontic accounts). Accounts will be referred to our collection agency after a period of 90 days has elapsed with no payment. A surcharge of 25% will be added to the balance.

5. In situations where a child's parents are not part of the same household (ex. divorce, separation, remarriage), we expect the parent who brings the child to the office to be fully responsible for all financial arrangements. If someone other than the parent who brings the child to the office wishes to be financially responsible then he/she must come to the office personally to make separate arrangements.

I have read the above financial policy. I understand and agree to all terms and conditions as stated.

Signed:________________________________ Date:____________________