John G. Fatse DMD LLC
John S. Scovic DDS

Cosmetic & Reconstructive Family Dentistry

Date:_____

M F

Last Name First Middle Date of Birth Sex Marital Status SSN

How would you like to be addressed? Email Address Cell Phone Number

Home Address City State Zip Code Home Phone Number

Name of Employer Occupation

Business Address City State Zip Code Work Phone Number

Insurance Information (Please fill out secondary insurance on the back)

Insured Member Last Name First Relationship SSN Date of Birth

Name of Employer Occupation Business Phone Number

Dental Insurance Co. Name Insurance Co. Address Insurance Co. Phone Number

Group Number _____ ID Number _____

How did you hear of our office?

Person responsible for account, if patient is a minor:

Last Name First Middle Relationship

Patient Signature:

Sign Name Date

If patient was assisted with this form, enter name of person assisting:

Print Name Sign Name Date

324 ELM STREET, SUITE 202A · MONROE, CT 06468 · 203-268-5051
www.johngfatsedmd.com
www.johnscovicdds.com

John G. Fatse, D.M.D., L.L.C.

Patient Medical History

Patient Name: Birth Date: Date Created:

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	

Are you using any medications, pills or drugs?

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics like Novicaine
☐ Clindamycin	☐ Amoxicillin		

Approximate date of last dental visit and reason for today's visit:

Dental Health

Do you clench or grind your teeth?	◯ Yes ◯ No	
Do your gums ever feel tender or swollen?	◯ Yes ◯ No	
Do you have pain in your jaw joints?	◯ Yes ◯ No	
Do foods or temperatures cause discomfort?	◯ Yes ◯ No	If yes
Do you avoid chewing or brushing any part of your mouth due to pain?	◯ Yes ◯ No	If yes
Have you ever had a serious problem associated with dental treatment?	◯ Yes ◯ No	If yes
Have you ever had a previous experience at the dentist that was a reason not to return?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Bruises Easily	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Low Blood Pressure	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Heart Attack/Heart Failure	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Heart Pacemaker	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No
Frequent Cough	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Epilepsy/Seizures	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Kidney Disease	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Cancer/Cancer Treatment	◯ Yes ◯ No	Radiation Treatment	◯ Yes ◯ No	Joint Replacement	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No

Have you ever had any serious illness not listed above or is there any other information you would like to share with us?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

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Payment Options

Payment in Full: Cash/Check/Debit/Credit/Health Savings Account on day of treatment.

- **Payment Plan:** (Balances over $500.00): Deposit of 50% of estimated treatment cost is due the day of procedure and remaining balance is due within 30 days of treatment. This payment option requires a signed credit/debit card authorization.
- **Outside Financing (Care Credit):** 0% financing over 12-24 months. No pre-payment penalties, subject to credit approval.

I have read and understand these payment options. All insurance payments are estimated and any difference or non-covered service is the patient's responsibility. I understand that unpaid balances are subject to a finance charge of 1% per month (12% APR) if balance is not paid after 30 days. By applicable state law, after 60 days we reserve the right to charge 15% in collection costs in addition court costs and a reasonable attorney fee for any unpaid balance.

_____ _____

Patient/Guardian Signature Date

Appointment Agreement

We understand that your time is valuable and we are constantly striving to make your experience here more pleasant. We make every effort to stay on time so that our patients will not have to wait unnecessarily. Your appointment is a commitment of time between you and our office and we ask that you make every effort to honor that commitment. If you find that you cannot keep your appointment, we do require a minimum notice of 48 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 48 hours, you may be subject to a $75.00 cancellation charge.

By signing below, I agree to fulfill my obligation as a patient and agree to the "broken appointment" fee should I not give proper notification.

_____ _____

Signature of patient or responsible party Date

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HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____