PLEASE PRINT CLEARLY Date: ______________________, 20________

Are any family members patients of this office? YES or NO If YES, who?____________________________________

How did you hear about our office? SIGN YELLOW PAGES CO-WORKER NEIGHBOR
FRIEND:____ OTHER:____

New Patient ***LEGAL*** Name: Mr./Mrs./Ms./Miss/Dr. ____
First Last Middle Initial
New Patient Address:____Apt. #____________
City______________________________State____________Zip______________________________
New Patient Work Phone Number: (_______)_______________Ext.___________ Pager (_______)_________________
New Patient Home Phone Number: (_______)__________________ Cell Phone (________)______________________
New Patient Social Security Number:___________--__________--_________ HEIGHT________ WEIGHT__________
New Patient E-Mail Address:________________________@____________________ New Patient Gender: Male / Female
New Patient Birthdate: Month_________________Day__________Year____________
New Patient Employer:____
New Patient Employer Address:____
City______________________________State_________Zip_________________________
New Patient Marital Status: Single Married Separated Divorced Widowed

New Patient DENTAL INSURANCE---PRIMARY
Name of Employee: First________________________Last_____________________________________M.I._____
Relationship of Employee to New Patient:____
Employee Social Security Number: _____________--_________--___________
Employee Birth date: Month______________________Day___________Year_________
Name of Employer:____
Address of Employer:____
City______________________________________State__________Zip__________________
Name of DENTAL INSURANCE COMPANY:____
Policy Number:____
Identification Number:____

New Patient DENTAL INSURANCE---SECONDARY
Name of Employee: First________________________Last_____________________________________M.I._____
Relationship of Employee to New Patient:____
Employee Social Security Number: _____________--_________--___________
Employee Birth date: Month______________________Day___________Year_________
Name of Employer:____
Address of Employer:____
City______________________________________State__________Zip__________________
Name of DENTAL INSURANCE COMPANY:____
Policy Number:____
Identification Number:____

PLEASE SIGN THE FOLLOWING SO THAT WE HAVE A “SIGNATURE ON FILE” FOR OUR INSURANCE BILLING NEEDS:

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

X ________________________________ _____________
Signed (Patient, or parent of minor) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the named dental entity.

X ________________________________ _____________
Signed (Patient, or parent of minor) Date

If new patient is under 18 years of age, please complete information for ONE parent.
If new patient is married, please complete spousal information.

Name: Mr./Mrs./Ms./Miss/Dr. ____
First Last Middle Initial
Address:____Apt. #__________
City___________________________State__________Zip____________
Work Telephone Number: (_______)________________________Ext.__________
Home Telephone Number: (_______)________________________
Mobile Telephone Number: (_______)________________________
Social Security Number: ____________--__________--____________
Exact LEGAL relationship to new patient:________________________

Person responsible for payment:

Name: Mr./Mrs./Ms./Miss/Dr. ____
First Last Middle Initial
Address:____Apt. #__________
City___________________________State__________Zip____________
Work Telephone Number: (_______)________________________Ext.__________
Home Telephone Number: (_______)________________________
Mobile Telephone Number: (_______)________________________
Social Security Number: ____________--__________--____________
Exact LEGAL relationship to new patient:________________________

Method(s) of payment: Cash Check Visa MasterCard Discover Insurance Finance Company Option

In case of an emergency, who should be notified?:

Name: Mr./Mrs./Ms./Miss/Dr. ____
First Last Middle Initial
Address:____Apt. #__________
City___________________________State__________Zip____________
Work Telephone Number: (_______)________________________Ext.__________
Home Telephone Number: (_______)________________________
Mobile Telephone Number: (_______)________________________

Exact **LEGAL** relationship to new patient:____________________________________

Physician or health facility used:

Name:____
Address:____Apt. #____________
City___________________________State__________Zip____________
Telephone Number: (_______)__________________________

- (WOMEN) - Do you suspect or are you pregnant?..Y N
- Has a physician ever told you that you **MUST** take antibiotics **PRIOR** to a dental visit?
  Why? ____
- Date of last physical examination: ____
- Are you currently under the care of a physician?..Y N
- Do you have any allergies (hives/ rash / difficulty breathing) to drugs/medications?...Y N
  To what drug(s) or medication (s)? ____
- Do you have any other allergies?..Y N
- Have you ever reacted adversely to any medication or drug?..Y N
- Are you presently taking any drug(s) or medication(s)?...Y N
  If so, what ____
- Have you ever been hospitalized for any reason including a major or minor operation?..Y N
  What and when? ____
- Have you ever had a serious accident involving head injuries?...Y N
- Do you suffer with headaches?...Y N
- Do you have epilepsy, seizures or fainting spells?...Y N
- Have you had a stroke?...Y N
- Do you have nervous problems?..Y N
- Are you receiving psychiatric care?..Y N
- Are you chemically dependent to drugs, alcohol, prescription drugs or medicines?..Y N
- Do you have sinus problems?...Y N
- Do you experience constant neck pain?... ....Y N
- Do you experience constant swollen neck glands?... ....Y N
- Do you wear contact lenses?..Y N
- Do you have a lung disease, tuberculosis, emphysema, asthma, chronic cough, bronchitis
  or other lung trouble?..Y N
- Do you have or have you had heart problems, damaged heart valves, chest pain,
  angina, a heart murmur, heart attack, an irregular heart beat,
  a pace maker or heart surgery?...Y N
- Do you have artificial heart valves or joints?..Y N
- Have you ever had rheumatic fever?...Y N
- Were you ever told that you have damaged heart valve(s) as a result of the rheumatic fever?.................................Y N
- Do you have high or low blood pressure?...Y N
- Do you have stomach, intestinal, or gall bladder problems?..Y N
- Do you have an ulcer?...Y N
- Have you recently experienced unintentional weight loss?...Y N
- Do you suffer with chronic diarrhea?..Y N
- Have you had hepatitis?...Y N
  Are you a carrier? ____
- Have you had jaundice (yellow skin)?..Y N
- Do you have liver disease?...Y N
- Do you have kidney problems?...Y N
- Are you on kidney dialysis?...Y N
- Have you had or do you have venereal disease(s) or sexually transmitted disease(s)?...Y N
- Have you had or do you have cancer?...Y N
- Have you ever received radiation as a treatment for a disease?...Y N
- Have you ever received chemotherapy as a treatment for a disease? ....Y N
- Have you ever experienced any growth, cysts or tumors? ....Y N
- Do you have AIDS, ARC, or other Immunosuppressive Disorders?...Y N
- Have you had a blood transfusion?...Y N
- Do you have a blood disorder(s) or disease(s) (e.g. anemia, hemophilia)?..Y N

- Do you bruise easily or have a bleeding tendency?....................Y N
- Do you have diabetes (blood sugar)?....................Y N
- Do you have circulatory problems?....................Y N
- Do you have arthritis?....................Y N
- Do you have back problems?....................Y N
- Are any teeth hurting you?....................Y N
- Is any part of your mouth sensitive to hot, cold, sweets or pressure?....................Y N
- Do you have any unhealed injuries, sores or ulcers in your mouth that you are aware of?....................Y N
- Have you experienced any growth(s) or sore spot(s) in your mouth?....................Y N
- Have you ever responded adversely to any dental treatment(s)?....................Y N
- Have you ever had any difficult extractions?....................Y N
- Have you ever had prolonged bleeding following an extraction?....................Y N
- Have you ever been numbed for dental work?....................Y N
- Do you get numbed for routine dental fillings?....................Y N
- Were you ever told that you had gingivitis?....................Y N
- Were you ever told that you have periodontal disease,pyorrhea, trench mouth or gum disease?....................Y N
- Have you ever had orthodontic treatment (braces)?....................Y N
- Do you know if you regularly clench or grind your teeth?....................Y N
- Do one or both of your jaw joints ever give you trouble?....................Y N
- Do you have pain in or near your ear(s)?....................Y N
- Do you chew on only one side of your mouth?....................Y N
- Do you brush?....................Y N
- Do you floss?....................Y N
- Do you use a soft toothbrush?....................Y N
- Do your gums bleed?....................Y N
- Do you smoke?....................Y N
- Do you chew tobacco?....................Y N
- Is your mouth always dry?....................Y N
- When was your last cleaning and check-up?___________ Were x-rays taken at that time?....................Y N
- When was your last dental visit? ____________________What was done? ____________________
- Were you raised in an area which had fluoride in the drinking water?....................Y N
  If not, did you receive fluoride supplements?....................Y N
- If under 18 years of age, does your drinking water contain fluoride?....................Y N
  If not, are you receiving fluoride supplements?....................Y N
  If YES, what DOSE are you receiving?________mg If NOT, why not? __________________

Name of previous dentist: ____
Address: ____
City, State, Zip: ____
Telephone Number: (________) ____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above, have been answered to my satisfaction. I will not hold my dentist, or any other members of his/her staff, responsible for any error or omissions that I may have made in the completion of this form.

X____ ________________________
Signature of adult PATIENT or parent/guardian if under 18 Date

<u>WRITTEN FINANCIAL POLICY</u>

Thank you for choosing the office of Dr. Ranzino. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options:

--Cash, Check, Visa, Mastercard, or Discover Card

--NO INTEREST Payment Plans from CareCredit (ask for details)

PATIENTS WITH INSURANCE COVERAGE

We will be glad to help you obtain the appropriate benefit from your insurance carrier and bill your carrier as a courtesy to you. However, you are responsible for the payments of the account.

We will be happy to request a pre-treatment estimate of benefits from your insurance carrier if you request us to do so. Routine treatment is generally performed without submitting a request for pre-treatment estimate of benefits.

Portions of the bill may not be paid by the insurance company and are to be paid by the patient. Sometimes there is a co-payment required by you as per your insurance agreement. Even if you have double coverage (this is possible if you and your spouse both have insurance), there may still be a portion that will be your responsibility.

If you are having treatment over a period of time, we appreciate payment during the course of treatment. Our receptionist will assist you in arranging a payment schedule.

PATIENTS WITHOUT INSURANCE COVERAGE

Patients without insurance coverage are requested to pay for services as rendered.

ADDITIONAL TERMS

Appointments canceled with less than 24 hours notice are subject to a **$50.00** cancellation charge. Checks returned by your bank are subject to a **$50.00** processing charge. Accounts unpaid after 30 days from the date of billing are subject to a finance charge at the rate of 1 1/2% per month (18% per annum). If your account is referred for collection, you will be responsible for collection costs in the amount of **30%** of the outstanding balance, together with court costs and reasonable attorney's fees.

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide you with the best care possible.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE OFFICE OF DR.VINCENZO RANZINO.

X____ ______________, 20_______

Signature of adult PATIENT OR parent/guardian if under 18 Today's Date