Dr. Gregg Michael Festa, D.D.S. • 8410-A Falls of Neuse Road • Raleigh, NC 27615

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ❑ M ❑ F Age _____ Birth date _____

❑ Single ❑ Married ❑ Widowed

❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Spouse's Name _____

Birth date _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you, and/or how did you find out about our practice?

_____

_____

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Insurance Co. Address _____

_____

City State Zip

Subscriber's Name _____

Birth date _____ SS# _____

Relationship to Patient _____

ASSIGNMENT AND RELEASE

I, the undersigned am financially responsible for this account. I assign directly to Gregg Michael Festa D.D.S. all insurance benefits, if any. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date

CONTACT INFORMATION

Home Phone _____ Cell _____ Work _____ Spouse's Work _____

Email _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.) _____

Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

DENTAL HISTORY

Is there anything you would like to change about your smile? _____

_____

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date and reason for last dental visit

_____

Date of last dental X-rays _____

Place a mark on "Yes" or "no" to indicate if you have had any of the following:

Bad breath	❑ Yes	❑ No
Bleeding gums	❑ Yes	❑ No
Blisters on lips or mouth	❑ Yes	❑ No
Broken Fillings	❑ Yes	❑ No
Chew on one side of mouth	❑ Yes	❑ No

Cigarette, pipe, cigar smoking, or oral tobacco use	❑ Yes	❑ No
Clicking or popping jaw	❑ Yes	❑ No
Dry Mouth	❑ Yes	❑ No
Food collection between the teeth	❑ Yes	❑ No
Foreign objects	❑ Yes	❑ No
Grinding or clenching teeth	❑ Yes	❑ No
Gums swollen or tender	❑ Yes	❑ No
Jaw pain or tiredness	❑ Yes	❑ No
Loose teeth	❑ Yes	❑ No
Mouth pain	❑ Yes	❑ No
Orthodontic treatment	❑ Yes	❑ No
Peridontal treatment	❑ Yes	❑ No

Sensitivity to cold	❑ Yes	❑ No
Sensitivity to heat	❑ Yes	❑ No
Sensitivity to sweets	❑ Yes	❑ No
Sensitivity when biting or chewing	❑ Yes	❑ No
Sores or growths in your mouth	❑ Yes	❑ No
Tooth pain	❑ Yes	❑ No

How often do you floss?

_____

How often do you Brush?

_____

OVER (More information on back)

Patient's Name _____

HEALTH HISTORY

Physician's Name _____ Date and reason for last visit _____

Physician's Phone # _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Do you have to pre-med (take an antibiotic) prior to a dental appointment? ❑ Yes ❑ No

AIDS	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No	Type _____			Skin Rash	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	Type _____			Swollen Neck Glands	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Bleeding abnormally, with extractions or surgery	❑ Yes	❑ No	HIV Positive	❑ Yes	❑ No	Tumor or growth on head or neck	❑ Yes	❑ No
			Kidney Disease	❑ Yes	❑ No			
Blood Disease	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Ulcer	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No	Weight Loss, unexplained	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Nervous Problems	❑ Yes	❑ No	Any conditions that could affect dental treatment _____		
Circulatory Problems	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No			
Congenital Heart Lesions	❑ Yes	❑ No	Pregnant?	❑ Yes	❑ No			
Diabetes	❑ Yes	❑ No	Due Date _____					
Epilepsy	❑ Yes	❑ No	Are you nursing	❑ Yes	❑ No			
Fainting or dizziness	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No			
Headaches	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No			
Heart Murmur	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No			
Heart Problems	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No			

MEDICATIONS

List medications you are currently taking and what conditions each is for _____

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Acetaminophen (Tylenol)
❑ Hydrocodone (Vicodin)
❑ Ibuprofen (Advil)
❑ Iodine
❑ Latex
❑ Local Anesthetic
❑ Nickel
❑ Penicillin
❑ Sulfite (Metabisulfite)
❑ Other _____

_____

_____

UPDATES

(To be filled in at future appointments)

DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. Our staff works as a team to provide dental expertise as well as old-fashioned courtesy and compassion. In order to achieve these goals, we need your assistance and your understanding of our financial policies.

Payment for services is due at the time services are rendered. We accept cash, checks and credit cards.

If you have dental insurance we are anxious to help you receive your maximum allowable benefits. As a courtesy to our patients, we will file and accept payment directly from your insurance company. Since most insurance companies do not pay 100%, you are responsible for your portion at the time of your appointment. Our office will estimate your portion. Please keep in mind this is only an estimate.

If after 30 days from the day services are rendered your insurance company has not paid for any reason, you are responsible for the balance. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you!

I, the undersigned, authorize dental treatment.

DATE: _____ SIGNED_____

I, hereby authorize my insurance company to assign benefits directly to Dr. Gregg Michael Festa DDS. I have read and understand the above.

DATE: _____ SIGNED_____

DR. GREGG MICHAEL FESTA DDS

8410-A FALLS *of* NEUSE ROAD RALEIGH NC 27615 919.847.3899

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

DR. GREGG MICHAEL FESTA, D.D.S.
8410-A Falls of Neuse Road
Raleigh, NC 27615
919-847-3899

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.