

# WELCOME

## 1

### ABOUT YOU

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ File #: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_ ☐ Male ☐ Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: \_\_\_\_\_

Do you have children? ☐ Yes ☐ No How many? \_\_\_\_\_

## 3

### ACCOUNT INFO

Person ultimately responsible for account

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY STATE ZIP

SS #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

Payment method: ☐ Cash ☐ Check

☐ Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

## 2

### INSURANCE INFO

#### Primary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

#### Secondary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

## 4

### EMERGENCY CONTACT

Whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

Medical Doctor's Phone #: (\_\_\_\_) \_\_\_\_\_

CONTINUE ON BACK



Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation Are you in pain? ☐ No ☐ Yes How Long? \_\_\_\_\_

Please indicate ☒ any of the following problems:

☐ Discomfort, clicking or popping in jaw ☐ Lost/Broken Filling(s) ☐ Stained teeth ☐ Broken/Chipped tooth

☐ Blisters/Sores in or around the mouth ☐ Teeth grinding ☐ Locking Jaw ☐ Sensitive tooth, teeth or gums

☐ Red, swollen or bleeding gums ☐ Ringing in Ears ☐ Bad breath ☐ Active Decay/Cavity(ies)

☐ Other: \_\_\_\_\_

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know Have you ever been treated for Gum Disease? ☐ Y ☐ N

Previous Dentist: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Name Address Phone#

Last Dental exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last Dental X-rays: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last Dental Cleaning: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you had problems with previous dental treatment? If so, explain: \_\_\_\_\_

Times a day you brush? \_\_\_\_ Times a week you floss? \_\_\_\_ Type of tooth brush bristles? ☐ Soft ☐ Medium ☐ Hard

Rate your Smile from 1-10: (EXCELLENT=10) \_\_\_\_ Would you like whiter teeth? ☐ Y ☐ N Have you had orthodontic treatment? ☐ Y ☐ N

Things you would change about your smile? \_\_\_\_\_

**What medications are you taking?** ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants

☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis ☐ Vitamins/Supplements \_\_\_\_\_

☐ Other(s), please list: \_\_\_\_\_

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ☐ Yes ☐ No Phen-fen/Redux ☐ Yes ☐ No

**Do you have or have you had any of the following diseases, medical conditions or procedures?**

<input type="checkbox"/> Y N Heart Murmur	<input type="checkbox"/> Y N Heart Attack/Stroke	<input type="checkbox"/> Y N Heart Surg./Pacemaker	<input type="checkbox"/> Y N Heart Disease/Angina	<input type="checkbox"/> Y N Shingles
<input type="checkbox"/> Y N Lung Disease	<input type="checkbox"/> Y N Thyroid Problems	<input type="checkbox"/> Y N Congenital Heart Defect	<input type="checkbox"/> Y N Cancer/Tumor(s)/Growth(s)	<input type="checkbox"/> Y N Hepatitis
<input type="checkbox"/> Y N Liver Problems	<input type="checkbox"/> Y N Seizures/Epilepsy	<input type="checkbox"/> Y N Artificial Heart Valves	<input type="checkbox"/> Y N Chemotherapy/Radiation	<input type="checkbox"/> Y N Glaucoma
<input type="checkbox"/> Y N Blood Disease	<input type="checkbox"/> Y N Venereal Disease	<input type="checkbox"/> Y N Mitral Valve Prolapse	<input type="checkbox"/> Y N X-ray or Cobalt Treatment	<input type="checkbox"/> Y N Arthritis/Gout
<input type="checkbox"/> Y N Kidney Problems	<input type="checkbox"/> Y N Cosmetic Surgery	<input type="checkbox"/> Y N G.I. Problems/Ulcers	<input type="checkbox"/> Y N Frequent Thirst/Urination	<input type="checkbox"/> Y N Leukemia
<input type="checkbox"/> Y N Scarlet Fever	<input type="checkbox"/> Y N Dizziness/Fainting	<input type="checkbox"/> Y N Emphysema/Asthma	<input type="checkbox"/> Y N Bleeding Problems/Anemia	<input type="checkbox"/> Y N Chest Pains
<input type="checkbox"/> Y N Tuberculosis TB	<input type="checkbox"/> Y N Cold/Fever Blisters	<input type="checkbox"/> Y N Diabetes/Hypoglycemia	<input type="checkbox"/> Y N High/Low Blood Pressure	<input type="checkbox"/> Y N Bruise Easily
<input type="checkbox"/> Y N HIV+/AIDS/ARC	<input type="checkbox"/> Y N Blood Transfusion	<input type="checkbox"/> Y N Psychiatric Problems	<input type="checkbox"/> Y N Artificial Bones/Joints/Implants	<input type="checkbox"/> Y N Allergies
<input type="checkbox"/> Y N Rheumatic Fever	<input type="checkbox"/> Y N Alcohol/Drug Abuse	<input type="checkbox"/> Y N Back/Neck Problems	<input type="checkbox"/> Y N Severe/Frequent Headaches	<input type="checkbox"/> Y N Nervousness
<input type="checkbox"/> Y N Sinus Problems	<input type="checkbox"/> Y N Eating Disorder	<input type="checkbox"/> Y N Respiratory Problems	<input type="checkbox"/> Y N Jaw Problems TMJ/TMD	<input type="checkbox"/> Y N Sleep Apnea

Please list any other surgeries or medical conditions you have or ever had: \_\_\_\_\_

Are you allergic to any of the following? ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Codeine

☐ Dental Anesthetics ☐ Foods: \_\_\_\_\_ ☐ Others: \_\_\_\_\_

Do you use tobacco? ☐ No ☐ Yes/How used? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

Please rate your general health from 1-10: \_\_\_\_\_ Do you wear contact lenses? ☐ Yes ☐ No

**For women:** Are you taking Birth Control pills? ☐ Yes ☐ No Are you taking hormonal replacement? ☐ Yes ☐ No

Are you Pregnant? ☐ No ☐ Yes/How long? \_\_\_\_\_ Are you nursing? ☐ Y ☐ N How many children have you had? \_\_\_\_\_

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that I have received a copy of the Summary of Privacy Notice.

Initials

Signature

☐ Adult Patient

☐ Parent or Guardian

☐ Spouse

Date

/

/

**UPDATE**  
(OFFICE USE)

Initials

Date

Comments

Initials

Date

Comments

Initials

Date

Comments



**THOMAS J. MANZIONE, D.D.S.**

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**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND  
CONSENT/LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. If you refuse, we may not be allowed to process your insurance claims.

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the THOMAS J. MANZIONE, D.D.S.. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE SHALL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST DOCUMENTS BE SENT TO OTHER ATTENDING DOCTORS/TREATMENT FACILITIES IN THE FUTURE. I MAY CANCEL THIS RELEASE WITH A SIGNED WRITING AT ANY TIME.

\_\_\_\_\_  
Printed name of Patient

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Printed name of Guardian

\_\_\_\_\_  
Relationship of Guardian

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION (including step parents, grandparents, and any other care takers who are allowed access to this patient's records):

Name: \_\_\_\_\_  
Name: \_\_\_\_\_

Relationship: \_\_\_\_\_  
Relationship: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT, & BILLING INFORMATION VIA:

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Cell Phone Confirmation | Cell Phone Number(s) _____         |
| <input type="checkbox"/> Home Phone Confirmation | Home Phone Number _____            |
| <input type="checkbox"/> Email Confirmation      | Authorized Email Address _____     |
| <input type="checkbox"/> Work Phone Confirmation | Authorized Work Phone Number _____ |
| <input type="checkbox"/> Any of the Above        |                                    |

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Cell Phone Confirmation | Cell Phone Number(s) _____         |
| <input type="checkbox"/> Home Phone Confirmation | Home Phone Number _____            |
| <input type="checkbox"/> Email Confirmation      | Authorized Email Address _____     |
| <input type="checkbox"/> Work Phone Confirmation | Authorized Work Phone Number _____ |
| <input type="checkbox"/> Any of the Above        |                                    |

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUNDRAISING EFFORTS, OR NEW HEALTH INFORMATION ON BEHALF OF THIS FACILITY VIA:

- |  |                            |
|--|----------------------------|
| <input type="checkbox"/> Cell Phone Confirmation | Cell Phone Number(s) _____ |
|--|----------------------------|

# Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your/their age over 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.**

- For testing, see the list of [State and Territorial Health Department Websites](#) for your specific area's information.