Date _____

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	❑ M ❑ F	Email

Primary Insurance Company _____ Group _____ Subscriber _____

Secondary Insurance Company _____ Group _____ Subscriber _____

Responsible Party

NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City	State Zip

How did you hear about our Office?

(check only one)

Who selected this Office? ❑ Self ❑ Spouse ❑ Parent ❑ Employer

Where did you find the Phone Number to this Office? _____

❑ Referred by a friend ❑ Yellow Pages ❑ Relative ❑ Insurance Plan ❑ Welcome Wagon

❑ Other_____ ❑ TV/Radio Ad ❑ Newspaper Ad ❑ Direct Mailing ❑ Sign by Building

If you were referred, whom may we thank for referring you? _____

CONSENT

•I will answer all health questions to the best of my knowledge _____
Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature Date Relationship to Patient

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.
As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed_____ **Date**_____

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.)_____

Previous Dentist_____ Last Visit_____ Date of last cleaning_____

Reasons for changing dentists:_____

What problems have you had with past dental treatment?_____

Are you nervous about seeing a dentist? ❑ Yes! ❑ No If yes, please tell us why:_____

How often do you brush?_____ Do you floss? ❑ Yes ❑ No How often?_____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straight.
Y N I want my teeth whiter.

What are your dental priorities?_____
(e.g.: apprentice, dental health, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

I consider my health to be *(please check one)* ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you or have you had any of the following? *please circle Y for yes or N for no.*

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: ❑ Hip ❑ Knee ❑ Other
16. Y N I smoke or use tobacco. If yes, how much per day?_____ How many years?_____
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery: Year_____Type of operation:_____Year_____Type of operation:_____
21. Y N Do you have any other medical problem or medical history NOT listed on this form?_____
22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type____
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis (Mono)
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Disease
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation Treatment
35. Y N History of Drug Addiction
36. Y N AIDS
37. Y N Immune Suppressed Disorder
38. Y N Hearing Loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders

Doctor Notes Only:

WOMEN

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

Are you allergic to any of the following?
Please circle Y for yes or N for no

44. Y N Aspirin
45. Y N Ibuprofen
46. Y N Sulfa Drugs/Sulfites/Sulfides
47. Y N Penicillin
48. Y N Codeine
49. Y N Latex, Metals, Plastics
50. Y N Local Anesthetics (Novocaine)
51. Y N Other Medications - Which ones?_____

Please list all medications you are currently taking:

Medicine_____Condition_____
Medicine_____Condition_____
Medicine_____Condition_____
Medicine_____Condition_____
Physician's Name_____Phone_____
Address_____Fax_____

In the event of an emergency please contact:

Name_____Relationship_____Phone_____
Name_____Relationship_____Phone_____

Initial medical/dental health reviewed by:

X_____/____/____ (Doctor's Signature / Date) X_____/____/____ (Patient's Signature / Date)

Periodic medical/dental health reviewed by:

X_____/____/____ (Doctor's Signature / Date) X_____/____/____ (If patient is a minor: Parent/Guardian's Signature / Date)

GETTING TO KNOW YOU AS OUR PATIENT

CARRIE A. GIULIANO, DDS, PC

WWW.CARRIEGIULIANODDS.COM

CONSENT

1. I authorize Dr. Carrie Giuliano and staff to take all necessary X-RAYS, STUDY MODELS AND OTHER DIAGNOSTIC AIDS as needed to make a thorough diagnosis.

2. I authorize Dr. Carrie Giuliano to PERFORM ALL RECOMMENDED AND AGREED UPON TREATMENT.

3. I AM RESPONSIBLE FOR PAYMENT for all services rendered on my behalf and my dependents. I have been informed that PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, unless prior arrangements have been made. I am aware that a 2.0% finance charge is automatically tabulated if my account is 60 days or older. Should my account become delinquent, I will assume all additional collection costs and legal fees.

4. I understand that a BROKEN APPOINTMENT FEE will be charged to my account for all broken (no call/no show) appointments or appointments that are not cancelled/rescheduled at least 24 hours prior to the appointment time. The amount of the broken appointment fee will be $75 per hour. Please be courteous and cancel in advance if you are unable to make it to your appointment. If we know in advance that you will be unable to keep your appointment, we can contact someone on the stand-by list to come in at your appointment time.

Patient/Responsible Party_____Date_____ -

INSURANCE PATIENTS

I authorize Dr. Carrie Giuliano to submit claims for payment for services rendered or pre-authorizations if necessary to my insurance company on my behalf and in my name listed as "Signature on File," and assign to Dr. Carrie Giuliano the dental insurance benefits. We are happy to file insurance claims for our patients. As a courtesy to you, we follow up on your claim for 45 days. If the claim remains outstanding after 45 days, we will then close the claim and any unpaid balance becomes your responsibility. Should you need any documentation from our office in your correspondence with the insurance company, we will be glad to provide it for you.

I understand that insurance coverage is only an estimate. I understand that I am responsible for the cost of all treatment not covered by my insurance.

Patient/Responsible Party_____Date_____

P:: 646.225.6677 :: 201 EAST 17TH STREET · NEW YORK, NY 10003
CARRIEDDS@GMAIL.COM

CARRIE A. GIULIANO, DDS, PC
WWW.CARRIEGIULIANODDS.COM

Credit Card Authorization Form

Name _____ Date _____

Card Number _____

Expiration and Security Code _____

I, _____, hereby authorize the office of Dr. Carrie Giuliano to charge my card in the event I do not follow their broken appointment policy.

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