Pascack Valley Dental Practice, P.A.

Philip Spagnesi, D.D.S.
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449 Old Hook Rd.
Emerson, NJ 07630

Tues: 9:00 am -8:00 pm
Wed: 9:00 am - 12:00 pm
Thurs: 9:00 am -8:00 pm
Sat: 9:00 am - 2:00 pm

AUTHORIZATION FOR RELEASE OF RECORDS

I,_____, hereby request that a copy of my dental records be transferred to the office of Pascack Valley Dental Practice, P.A. Please e-mail all diagnostic quality digital xrays to PVDental2@aol.com.

_____

Signature of Patient (or Parent/Guardian)

_____

Date

PASCACK VALLEY DENTAL PRACTICE PATIENT REGISTRATION

THE OFFICE OF DR. PHILIP SPAGNESI DDS AND DR. CRAIG SALIZZONI DMD

Thank you for choosing our office to assist you with your dental needs. Please fill out the information below.

PATIENT INFO

Patient Name: Last First MI			**JR, SR, II, III, etc:**	**Birthdate:** / **Sex:**
Street Address:	**City:**		**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Work Phone:**	**Email:**	
Social Security #: _____-____-_____	**If under age 18, name of Parent or Legal Guardian:**		**Marital Status:**	**Spouse's Name**
Height: / **Weight:**	**Occupation:**	**Referred by:**		**Today's Date:**

-Medical Health History-

Primary Medical Physician:_____ **Phone:**_____

□ **Are you required to Pre-medicate (take antibiotics) prior to dental treatment/cleanings? Yes No**

Do you have, or have you had any of the following? (check all that apply):

- □ Artificial Joints or heart valves
- □ Thyroid problems
- □ Blood Problems (Anemia, etc)* (please specify):_____
- □ Blood Transfusion (please specify):_____
- □ Heart Problems/Murmur, mitral valve prolapse, heart defect, congenital defect/lesions
- □ Cardiovascular disease (heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke, other)
- □ Cardiac Pacemaker
- □ Kidney Trouble
- □ Bone or Joint problems
- □ Cancer
- □ High or Low Blood pressure (circle one)
- □ Tuberculosis, COPD, or other lung problems
- □ Hepatitis, jaundice, or other liver disease
- □ Diabetes Type 1 or Type 2 (circle one)
  - □ Urinate more than six times a day?
  - □ Consistent thirst
  - □ Frequent dry mouth
- □ Epilepsy or Neurological disorder
- □ Fainting spells
- □ Psychiatric Problems
- □ Arthritis or Rheumatism
- □ AIDS, HIV or other Auto-immune disorder (circle one)
- □ Abnormal bleeding after surgery/bruise easily
- □ Hayfever/Sinus trouble
- □ Asthma
- □ Allergies

Do you smoke, vape, chew or use tobacco products? Yes No

Have you had surgery, x-ray, or drug treatment for a tumor, growth, or other condition of your head or neck: Yes No

*If yes, explain:_____

_____

Have you had any serious illness or operation? Yes No

*If yes, explain:_____

_____

Have you been hospitalized or have you had a serious illness within the past five years: Yes No

*If yes, explain:_____

_____

Have you ever been diagnosed with Sleep Apnea? Yes No

****If Yes, are you currently using an oral appliance, CPAP/AutoPAP or other form of treatment? (circle one)**

Are you allergic to, or have you reacted adversely to any of the following?:

- □ LATEX
- □ Penicillin/antibiotics
- □ Sulfa drugs
- □ Codeine or other narcotics
- □ Aspirin
- □ Other:_____

Are you currently taking any of the following?:

- □ Antibiotics or sulfa drugs
- □ Aspirin
- □ Antihistamines
- □ Anticoagulants/blood thinners (e.g. Coumadin, etc)
- □ High blood pressure medicine
- □ Anti-depressants or tranquilizers
- □ Insulin tolbutamide (Orinase, or similar drug)
- □ Digitalis or drugs for heart trouble
- □ Nitroglycerin
- □ Cortisone or other steroids
- □ Osteoporosis (bone density) medicine
- □ Natural supplements/vitamins/etc
- □ Other: Please complete section "RX List" on page 2

Women, are you (check all that apply):

- □ Pregnant
- □ Taking hormones or oral contraceptives?
- □ Nursing?

Pascack Valley Dental Practice Patient Registration

The office of Dr. Philip Spagnesi DDS and Dr. Craig Salizzoni DMD

Thank you for choosing our office to assist you with your dental needs. Please fill out the information below.

INSURANCE INFO

☐ Check here if not covered by dental insurance

Dental Insurance Company:	ID# or Subscriber Social Security #:	Group #:	Group Name/Employer:

Insurance Claims Address:	City:	State:	Zip:	Payor ID#

Subscriber Name: (If different from patient)	Subscriber Birthdate:	Relationship to Subscriber: Self Spouse Child Other

SECONDARY INSURANCE INFO

☐ Check here if not covered by secondary dental insurance

Dental Insurance Company:	ID# or Subscriber Social Security #:	Group #:	Group Name/Employer:

Insurance Claims Address:	City:	State:	Zip:	Payor ID#

Subscriber Name: (If different from patient)	Subscriber Birthdate:	Relationship to Subscriber: Self Spouse Child Other

RX List

Have you ever had any abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No

*If Yes, please explain:_____

_____

Have you had any serious trouble associated with any previous dental treatment? Yes No

*If Yes, please explain:_____

_____

Do you have any disease, condition, or problem not listed that you think we should know about? Yes No

*If Yes, please explain:_____

_____

*Emergency Contact Name: _____ Phone:_____ Relation:_____

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 member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient or Guardian Signature:_____ Date:_____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the 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 (e.g. my insurance company);
- The day-to-day healthcare operations 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 that 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.

Signed this _____ day of _____, 20___.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: Pascack Valley Dental Practice, P.A.

Address: 449 Old Hook Road

City/State/Zip: Emerson, NJ 07630

PASCACK VALLEY DENTAL PRACTICE
449 OLD HOOK ROAD
EMERSON, NEW JERSEY 07630
(201) 265-8600

OUR OFFICE POLICIES

FINANCIAL POLICY:

Thank you for selecting us as your dental care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy.

Because of the tremendous increase in costs involved in billing, and in an attempt to contain costs for all our patients, we must ask you to read and sign this financial policy prior to any treatment. Please return the original to our front desk, keeping a copy for your records. In addition, full payment is due at the time of service, unless other arrangements have been discussed. We accept cash, checks, and Visa/Mastercard.

REGARDING INSURANCE:

If you have dental insurance, it should be understood that this is an aggreement between you and your insurance company to pay a certain portion of your dental care. As a courtesy to you, we will submit your insurance claims. Your doctor's bill however, is an agreement between you and your doctor. You are responsible for the payment of your bill regardless of the status of your insurance claim.

If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to call, or personally discuss the matter with our front desk personnel. This will avoid misunderstandings and enable you to keep your account in good standing.

For accounts over 90 days, it is understood that a finance charge of 1.5% per month, on any balance, as well as all collection, court costs, attorney fees, and interest fees will be added to your account.

Our practice provides the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS:

Time is precious, to you and to our practice. You may expect us to be on time, and we will expect the same courtesy. We request your cooperation in canceling any appointment at least 24 hours in advance, so that another patient may use that time. We reserve the right to bill for missed appointments at the rate of a normal office visit.

Thank you for your understanding and cooperation.
Please feel free to call us with any questions or concerns.

_____

Signature of patient or responsible party Date