Welcome To The Office of CJ Falvello DDS, MAGD, ABGD
General and Implant Dentistry

Today's Date: _____ How were you referred to our office? _____

Patient's Name: _____ If Minor, Parents/Guardian: _____

Birth Date: _____ Social Security #: _____ – _____ – _____ Sex: M F Martial Status: S M W D

Home Address: _____ City: _____ State: _____ Zip: _____

Telephone (Home): _____ (Work): _____ (Cell): _____ E-Mail: _____

Medical History

Physician's Name(s): _____

List **ALL** prescriptions or over the counter medicines you are currently taking: _____

_____

List any serious medical condition(s) that you have had in the past 5 years: _____

Have you ever had any of the following diseases or medical problems? Please circle

Y N Rheumatic Fever	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Heart Disease	Y N Artificial Valves	Y N Artificial Bones/Joints
Y N Heart Attack/Stroke	Y N Heart Surgery/Pacemaker	Y N Heart Murmur
Y N Cancer/Chemotherapy	Y N Hepatitis	Y N HIV+/AIDS
Y N Psychiatric Treatment	Y N Tuberculosis	Y N Epilepsy/Seizures/Fainting
Y N Anemia/Blood Transfusions	Y N Hemophilia/Abnormal Bleeding	Y N Taking Bloodthinners
Y N Glaucoma/Cataracts	Y N Asthma/Lung Problems	Y N Aspirin/Coumadim/Plavix
Y N Severe/Frequent Headaches	Y N Diabetes	Y N Sinus Problems
Y N Seasonal Allergies	Y N Currently Pregnant/Nursing	Y N Recreational Drugs/Addictions
Y N Osteoporosis/Fosamax/Boniva/Actonel	Y N Daily Alcohol Use _____	
Y N Other (please list): _____		

Are you allergic to any of the following? Please circle

Y N Penicillin	Y N Erythromycin	Y N Tetracycline	Y N Aspirin
Y N Codeine	Y N Dental Anesthetic	Y N Latex	Y N Other _____

Do you smoke? Y N If yes, how much per day? _____ How long have you been a smoker? _____

Are you currently experiencing dental discomfort? ____ If yes, where? _____

Date of last dental visit: _____ Treatment received: _____

Why have you come to the dentist today? _____

Method of Payment (circle) **CASH** **CHECK** **CREDIT CARD** **CARE CREDIT FINANCING**

Name of Dental Insurance Carrier: _____

Subscriber's Name: _____ Group #: _____ ID #: _____

Subscriber's Birthdate: _____ Subscriber's Social Security #: _____ – _____ – _____

Employer: _____ Address: _____

Employer's Telephone: _____ Secondary Insurance? YES NO

* I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment, this includes radiographs (x-ray films). I give my consent for Dr. Falvello to take photos or other images of my teeth for use in an educational setting and that my identity will not be revealed.

*I understand that I AM RESPONSIBLE for charges incurred by me, regardless of Insurance. I understand that Insurance payment is not always payment in full and I AM RESPONSIBLE for any Deductibles, Co-Payments or Non-covered services and I will resolve any outstanding balance in a timely manner.

Finance charges of 1.5% per month on balances greater than 30 days old will accrue. All expenses incurred in the collection of past due accounts becomes the responsibility of the debtor.

X _____ DATE: _____

RADIOLOGY INFORMATION AND CONSENT

Radiographs (x-ray pictures) are an essential part of dental treatment.

We all know that the benefits we receive from these pictures far outweigh the risks of exposing the body to the small amount of x-radiation in dental radiographs. All of our x-ray pictures are digital.

We still believe in being as conservative as possible in our x-ray policy.

So our recommendation for *screening radiographs* for our patients is as follows:

Panoramic film: Shows all the teeth & both jaws in one picture; taken once every 3-5 years. Fee $ 108.00

Bitewing film: Shows the areas between the teeth that we can't see when we look in the mouth. We take them as needed in children, every 6 months in teenagers, & every 6-24 months in adults. Fee $ 65.00

I have read and understand the above information regarding *screening radiographs*. I understand that additional films, called periapicals, may be necessary in emergencies or when there is deep decay or gum disease, or as part of a comprehensive evaluation of my mouth. Fee $33 each

** We will always discuss with you any x-ray images that Dr. Falvello recommends BEFORE taking them.

PLEASE CHECK ONE:

_____ I consent to any x-ray pictures, if deemed necessary by Dr. Falvello.

_____ I DO NOT consent to any x-ray pictures, even if deemed necessary by Dr Falvello.

SIGNATURE _____ DATE _____

Information Regarding Posterior (Back) Teeth Fillings

When a patient requires a filling in a back tooth, Dr. Falvello usually places a **resin** filling for his adult and child patients. These resin fillings are tooth-colored *most of the time*. He uses resin material for esthetics, material differences or to avoid using **amalgam** due to the mercury that it contains.

The fee for resin fillings is higher than the fee for amalgam fillings. Some dental insurance companies are providing an alternative benefit for tooth-colored resin fillings that are placed in posterior teeth. That is, the insurance will pay for the less expensive amalgam filling even though a resin was done. This means that the **patient** may be responsible for a **higher copayment or payment in full** depending on the rules of their dental insurance plan.

Please check one:

_____ I prefer to have **RESIN** material used for posterior tooth fillings.

_____ I prefer to have **AMALGAM** material used for posterior tooth fillings.

Patient Name _____

Signature of patient(or parent if minor)_____

Date_____

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ATTENTION ALL ADULT PATIENTS

We will now offer dental fluoride treatments for our adult patients. This will consist of applying a fluoride gel to the teeth using either a tray or brush delivery instead of the fluoride rinse you are used to. The gel is more effective than the rinse. All adults benefit from fluoride treatment, but especially if you are prone to decay, have dental sensitivity, are high-risk for decay due to medication or medical treatment such as radiation therapy or have root sensitivity or exposure.

The cost of the fluoride treatment for adult patients is $25 and is not included in with the cost of the cleaning. Some insurance companies MAY cover this benefit for adults; please check with your insurance plan.

Please check and sign below:

_____ I DO NOT wish to have a fluoride treatment at this time.

_____ I do wish to have a fluoride treatment at this time. I understand that I am responsible for the cost of this treatment.

_____
Signature

_____
Date

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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. 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:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

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.