guy g.
giacopuzzi
d.d.s.

Welcome To Our Practice...

We believe people should keep their teeth for a lifetime. Our goal is to bring you the best in dental care amidst a friendly environment. Your answers to the following questions are the first step in determining your immediate and long term dental needs. Add any comments you may have. The more we understand about your needs and concerns, the better we are able to care for you...

Patient Information *...so we can know you better...*

Name_____Birthdate_____Age____Home Phone_____

Cell Phone_____Work Phone_____Email_____

Mailing Address (POB)_____City, State, Zip_____

Marital Status_____ Dependent? Yes/No Social Security#_____Driver's License_____

Employer_____Occupation_____

Employer Address_____City, State, Zip_____

Whom may we thank for referring you?_____

Emergency Contact_____Phone_____

Who is financially responsible for this account?_____

Responsible Party *...who pays the bills...*

Name_____Birthdate_____Home/Cell phone_____

Relationship to patient_____Driver's License #_____

Social Security #_____

PO Box_____City, State, Zip_____

Employer_____Occupation_____Work phone_____

Medical History *...yes, we need to know....*

Family Physician_____Specialty_____

Address_____Phone_____

Additional Physician_____Specialty_____

Height_____Weight_____Date of Last medical exam_____

Please Circle...

Yes No Do you have a current medical problem? Describe_____
Yes No Do you have heart trouble? Describe_____
Yes No Have you had rheumatic fever? When_____
Yes No Do you have high or low blood pressure? Is it controlled?_____
Yes No Have you had pains in the chest or shortness of breath_____
Yes No Do your ankles ever swell?_____
Yes No Have you ever had a blood disorder?_____
Yes No Have you ever had a stroke? When_____
Yes No Have you had diabetes? Controlled?_____
Yes No Are you subject to fainting/dizziness? When?_____
Yes No Do you have headaches? How Often?_____
Yes No Are you allergic to any medication? Latex?_____
_____
Yes No Have you been told not to take certain medications? Describe_____
_____
Yes No Do you have asthma/hay fever? Controlled?_____
Yes No Have you had tuberculosis, HIV, or hepatitis? Type?_____
Yes No Do you have arthritis? Controlled?_____
Yes No Have you ever had a tumor and/or cancer? Treatment?_____
Yes No Have you had any major operations? List kind/date _____
Yes No Have you ever been in a serious accident? Describe/date_____
Yes No Are you taking any medications? Please list below...(name, dosage, condition)

Drug_____For_____Drug_____For_____
Drug_____For_____Drug_____For_____
Drug_____For_____Drug_____For_____
Drug_____For_____Drug_____For_____

Yes No Have you gained/lost weight this last year? (Circle) How much?_____
Yes No Do you become fatigued easily? Time of day?_____
Yes No Do you take more than one alcoholic drink/day? How many?_____
Yes No Do you vape or use any type of tobacco? How much? _____How long?_____
Yes No Do you have night sweats/unexplained fevers? How recently?_____

...For Women only...

Yes No Are you pregnant? Due date? Ever miscarried?_____
Yes No Have you reached menopause? Supportive medication?_____

For Office Use

B/P	ASA Class

Patient Signature_____Date_____

For office use...
ASA
Class_____Precautions_____Modifications_____Dr's Date/Sig_____

Dental History ...ah yes, the teeth–the most important part...

Previous Dentist_____City, Phone_____
Other previous dentists/specialists_____City, Phone_____
Last dental visit_____Last full mouth xrays_____Last complete exam_____
Your immediate dental concern?_____

Please Circle

Yes No Are you presently in dental pain? Where?_____
Yes No Have you had any unfavorable reaction to dentistry? Describe_____
_____
Yes No Have you lost teeth? From what cause?_____
Yes No Have you ever had orthodontic treatment?(braces) When?_____
Yes No Do you have growths/swellings in your mouth? How long?_____
Yes No Do you gums bleed when you brush?_____
Yes No Do you have an unpleasant taste/odor in your mouth? How long?_____
Yes No Do you floss? How often?_____
Yes No Did you lie on the previous question? Want to change your answer?_____
Yes No Have you ever been told you have pyorrhea, periodontal disease or gingivitis? When?_____
Yes No Do you have any biting or temperature sensitivity in your mouth? Where? How long?_____
_____
Yes No Have you ever had a bad reaction to a dental anesthetic? When?_____
Yes No Does food catch between your teeth? Where?_____
Yes No Do you have pain/soreness around your eyes, ears or other parts of your face? Where?_____
Yes No Do you have neck aches or headaches? Where? How often?_____
Yes No Do you ever awaken with an awareness of your teeth/jaws? How often?_____
Yes No Do you clench/grind your teeth during the day/night? (circle) How often?_____
Yes No Does your jaw joint (TMJ) pop, click or hurt at any time? Describe_____
Yes No Have you ever taken/been given drugs for osteoporosis? Describe_____
Yes No Do you fell you will eventually wear full artificial dentures?_____
Yes No Do any members of your family wear dentures? Parents?_____
Yes No Do you think your dental disease (periodontal or decay) is active?_____
Yes No Do you want to control your disease and retain your teeth? Or just let them fall out?_____
Yes No Are you concerned about the finances required to return your mouth to health?_____

Dental Fear/Phobia *...for those who hate dentists...*

Complete the following...

I really got frightened of going to the dentist when_____
_____

The most terrible dental experience I had was when_____
_____

I may do better at the dentists' office with (circle your choice...)
Oral sedation
IV sedation (twilight sleep)
Nothing at all but local anesthetic

Consent for Dental Treatment

This is my consent for Dr. Giacopuzzi and any auxiliary employed by him to perform the dentistry indicated in my personal chart, and any other procedure deemed necessary in the course of treatment. I also agree to the use of a local anesthetic and/or sedation depending on the judgement of Dr. Giacopuzzi. I understand that the practice of dentistry can involve variables which cannot be predicted, because of the variability of the human tissues involved. I understand that if I have withheld any information or not answered accurately the document known as "Health History", that I can place myself in a compromised situation which can result in serious harm, even death. (You may review your health history at this time, if you wish...)

Complication Risks

I understand that occasionally there are complications of dental treatment and anesthesia including but not limited to pain, infection, swelling, bleeding, facial discoloration, nausea, vomiting, bruises, numbness and tingling of the lip, tongue, chin, gums, cheeks and teeth, pain, numbness and thrombophebitis (inflamation of a vein) from intravenous and intramuscular injection, injury to and stiffening of neck and facial muscles, changes in the bite, temperomandibular joint problems, injury to adjacent teeth or restorations in other teeth, injury to other tissues, delayed healing, allergic reactions, stroke, heart attack and sinus complications. I further understand and accept the risk that complications may require hospitalization and may even result in death.

I understand that if I receive intravenous or oral sedation, that I agree to not take any medications beforehand, including alcohol, unless I first receive permission from Dr. Giacopuzzi. I understand that I must have someone else drive me home, and that I will not be able to drive or operate hazardous devices for at least 24 hours, or until fully recovered from the effects of the medications.

Local Anesthesia Risks

I understand that there are some risks associated with the use of local dental anesthetics (i.e., "novacaine"), including but not limited to infection, nerve injury, and permanent numbness. In understand that I can ask for a more complete discussion of this or any of the above risks if I desire.

I hereby accept the treatment plan and authorize release of all information related hereto to any insurance company or benefit provider under which I claim to be covered. I certify the truth of all personal information given. I have read (or have had read to me in a language I understand) the above consent and I fully understand that which I am signing.

Other Specific Risks

_____

_____ _____

Date Signature of patient, parent or guardian

Payment Options

Our mission is to deliver the finest, most cost effective dental health care available today. Following your diagnosis, the doctor will advise you of your plan for treatment, if any is necessary. Additionally, we will discuss the cost of the treatment with you.

Payment for your initial and future visits is due *at the time of treatment.* We have several payment options...

1) Cash or Check

2) Mastercard/Visa bank cards

3) Finance Plan

The first two are self explanatory. The finance plan is a separate line of credit independent of credit cards and their balances. There is an application, and it must be applied for *prior* to treatment.

Dental Insurances

We can accept payment from any dental insurance that allows you to select your own dentist. Please realize there are many procedures offered in this office that are not covered by insurance. Dental implant, implant related procedures, esthetic dentistry, and sedation are a few examples. If you have dental insurance, there is a co-payment (your portion) for most procedures. It is due at the time of treatment. Usually, a close estimate of that amount can be made, and it will be collected at the time of treatment. Over/under payments are settled after the insurance has paid.

I agree to payment at the time treatment is rendered. I will make payments with check/cash/bankcard/finance plan (circle your choice. If I have dental insurance, I understand that I, not the insurance company, am ultimately responsible for my bill. I have read and understand the foregoing and I understand the English language.

_____ _____

Signature of Patient or responsible party Date