Daniel J. Iannotti, DDS, Inc.

25880 Tournament Rd, Suite 106, Valencia CA 91355

PATIENT REGISTRATION

First Name: _____ Last Name: _____ M.I.: _____

Preferred Name: _____

Patient Information

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext: _____

Email Address: _____ Driver's License: _____

Social Security Number: _____ Birthdate: _____ Age: _____

Sex: ☐ Male ☐ Female

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

Preferred Method of Communication: ☐ Phone Call ☐ Text Message ☐ Email

How did you learn about our practice or whom may we thank for referring you? _____

Emergency Contact: _____ Phone Number: _____

Who is responsible for your account/payment? (if other than the patient) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____ Birthdate: _____

Primary Dental Insurance

Insurance Company: _____ Phone Number: _____

Whose name is the insurance under (subscriber name)? _____

Subscriber's Social Security Number: _____ Subscriber's DOB: _____

Group Number: _____ I.D. Number: _____

Subscriber's Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Employer offering this insurance: _____

Employer's Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

- If you have secondary dental insurance, please request an additional form from our front office staff member.

Dental History

Reason for today's visit: _____

Date of last dental care visit: _____ Date of last dental x-rays: _____

Name of previous dentist: _____

Reason for changing your dental home: _____

Do you have any specific dental concerns? _____

Are you currently experiencing any dental pain? _____

Are you happy with the appearance of your smile? _____

Are you interested in Sedation Dentistry? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor or their staff of any changes in this information.

_____

Patient or Guardian Name (printed) Patient or Guardian Signature

_____

Date Signed Witness Signature

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Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you take antibiotic pre-medication prior to dental procedures?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsilitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

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OFFICE POLICY REGARDING INSURANCE AND FINANCIAL AGREEMENT

1. Payment is expected at the time services are provided.

2. There will be a $25 dollar fee for checks that cannot be processed by the bank.

3. Appointment times are reserved especially for you. If you come in late, the Doctor may request that you reschedule the appointment. If you miss your appointment or cancel with less than 48 hours notice there will be a $75 cancellation fee. If for any reason you should need to change your appointment, there will be no charge, provided you give us 48 hour notice. Please help us serve you better by keeping your scheduled appointments.

4. If you have dental insurance and wish for us to bill your insurance company, we will do so as a courtesy to you. I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due and payable at the time services are rendered, regardless of whether or not my insurance benefits have been received.

5. We will collect a percentage of the treatment fee at the time treatment is provided (as per your particular insurance policy) and bill your insurance company as well. I understand that all services are due and payable at the time services are rendered unless other financial arrangements have been previously approved. Should my account exceed sixty days, one and one-half percent (1.5%) interest per month (18% per year) will be charged. There are no guarantees of insurance benefits. In the event of default of payment, I agree to be responsible for all attorney fees and other court costs.

I have read, fully understand and agree with the above information and consent to the treatment fees for services rendered at Dr. Dan Iannotti, DDS Inc. Whether my insurance company pays (partially or fully) for the treatments rendered, I am solely responsible for the treatment fees (which will be outlined in specific consent for treatment forms) when services are provided.

Patient Name (printed) Patient Signature

Date Signed Witness Signature

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PRIVACY CONFIDENTIALITY STATEMENT

This notice describes how dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of Information

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment, or health questions. Additional disclosures may be necessary to comply with Worker's Compensation and Public Health laws as well as judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by telephone or mail in the event a request of information is made.

Facility Set-Up

While our examination and treatment rooms are private, staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosures to others in the facility at the same time. If there is private information that you need discussed, please request to have such conversations in a private room.

Your Rights

1. You have the right to send us a written request to see or procure a copy of the information that we have about you, or amend your personal information, and we will refer you to the appropriate source, such as our doctors.
2. You have the right to request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances they may be prohibited by law.
3. You have the right to request that we communicate with you about medical matters using reasonable alternative means or at an alternative address.
4. You have the right to receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting.
5. You have the right to inspect and have a copy of your health information. There is no cost for the first copy. The cost for every subsequent copy will be $25.

Privacy Confidentiality Statement

You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is a disagreement you will be provided with information about our denial of your amendments and how you may appeal the denial of amendment. You also have the right to a copy of this notice upon request.

Complaints

Complaints about your privacy rights or how your privacy is handled at this office can be directed by calling this office. If you are not satisfied with how this office handles your complaint you may submit a formal complaint to the following address:

DHHD (Office of Civil Rights)

200 Independence Ave S. W.

Room 509F HHH Building

Washington, DC 20201

I have read the privacy notice and understand my rights contained in this notice. By signing this form I provide authorization and consent to use and disclose my protected health information as noted above.

Patient Name (printed) Patient Signature

Date Signed Witness Signature