

ED FRANCISCO DDS, PA
New Patient Forms

Patient Information:

First Name _____ MI ___ Last Name _____ Preferred Nickname _____
Address _____
City _____ State _____ Zip Code _____
Cell (____) _____ Home (____) _____ Work (____) _____
Email _____
Birthdate _____ Social Security Number _____
Gender (circle): M / F Marital Status (circle): Single Married Partner Other
Driver's License # and State of Issue _____
Emergency Contact _____ Relationship _____ Phone (____) _____
If patient is a minor, give parent's/guardian's name _____
Other family members seen by us _____
Who may we thank for referring you to our office? _____

Responsible Party Information (complete if different than patient above):

Full Name _____
Address _____
City _____ State _____ Zip Code _____
Cell (____) _____ Home (____) _____ Work (____) _____
Email _____
Birthdate _____ Social Security Number _____
Driver's License # and State of Issue _____

Employment Information:

The following information is for (please check):

- Patient
 Person responsible for payment

Employer _____ Occupation _____
Address _____
City _____ State _____ Zip Code _____

Dental Insurance Information:

Policyholder's First Name _____ MI ___ Last Name _____
Is policyholder a patient (circle)? Yes / No Patient's relationship to insured (circle): Self Spouse Child Other
Policyholder's DOB _____ Policyholder's SSN _____
Policyholder's Employer Name _____
Insurance Company / Plan Name _____
Policy ID Number _____ Group # _____
Insurance Claim Filing Address _____
City _____ State _____ Zip Code _____
Insurance Telephone Number _____

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Medical and Dental History:

Please fill out this section to the best of your knowledge. It is important for us to be aware of any health issues that may affect the treatment you received from our office. This information is kept strictly confidential.

Patient Name _____
Date of last dental visit _____ Name of prior dentist _____
Reason for today's visit _____
What concerns you most about your teeth? _____

Do any of the following apply to you (circle yes or no), and add any relevant comments at the end of the section.

1. Are you presently in any dental pain? Yes / No
2. Have you ever experienced any unfavorable reaction to dentistry? Yes / No
3. Have you ever lost or chipped any teeth? Yes / No
4. Have there been any injuries to face, mouth or teeth? Yes / No
5. Is any part of your mouth sensitive to temperature? Yes / No
6. Is any part of your mouth sensitive to pressure? Yes / No
7. Do you have any type of thumb or tongue habit? Yes / No
8. Are you a mouth breather? Yes / No
9. Do your teeth or jaws ever feel uncomfortable when you awake in the morning? Yes / No
10. Are you aware of your jaws clicking or popping? Yes / No
11. Are you aware of clenching your teeth during the day? Yes / No
12. Have you ever been told that you grind your teeth? Yes / No
13. Do you have tension headaches? Yes / No
14. Have you ever experienced chronic ringing in your ears? Yes / No

Comment regarding the above items: _____

Physician Name _____ Date of Last Physician Visit _____
Address _____
City _____ State _____ Zip Code _____
Phone _____

Are you currently taking any medication(s) including non-prescription medicine? Yes / No
If yes, list medication and dosage. _____

Have you ever taken any of the following (circle yes / no):

1. Fen-Phen/Redux Yes / No
2. Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Yes / No
3. Viagra, Revatio, Cialis or Levitra in the last 24 hours? Yes / No
4. Do you use controlled substances? Yes / No
5. Do you smoke, chew tobacco, or vape? Yes / No

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Medical and Dental History, continued:

Are you allergic to or have you had any reaction to the following medication (circle yes / no):

- | | | | |
|---------------------|----------|---|----------|
| • Local Anesthetics | Yes / No | • Penicillin, Tetracycline, or any other antibiotic | Yes / No |
| • Sulfa Drugs | Yes / No | • Aspirin | Yes / No |
| • Codeine | Yes / No | • Metal | Yes / No |
| • Sedatives | Yes / No | • Latex | Yes / No |
| • Iodine | Yes / No | • Other (please list) _____ | |

Are you currently under the care of a physician? Yes / No

If yes, please explain. _____

Have you had any major operations? Yes / No

If yes, please explain. _____

Have you ever been involved in a serious accident? Yes / No

If yes, please explain. _____

Have you been hospitalized for any surgical operations or serious illness in the past 5 years? Yes / No

If yes, please explain. _____

Medical Conditions (please circle any of the following that you have had or currently have):

- | | | |
|----------------------------|-------------------------------|------------------------------|
| • Allergies (pollen, dust) | • Drug Addition | • HIV/AIDS (circle) |
| • Anemia | • Emphysema | • Human Papillomavirus HPV |
| • Angina/Chest Pain | • Epilepsy/Convulsions | • Kidney Disease |
| • Anxiety/Nervous Disorder | • Excessive/Abnormal Bleeding | • Liver Disease |
| • Arthritis/Gout | • Excessive Thirst | • Mitral Valve Prolapse |
| • Artificial Heart Valve | • Fainting/Seizures | • Nursing |
| • Artificial Joint | • GI Disorders/Acid Reflux | • Pneumonia |
| • Asthma | • Glaucoma | • Pregnant or Attempting |
| • Blood Pressure Low | • Heart Attack/Failure | • Taking Oral Contraceptives |
| • Blood Pressure High | • Heart Disease | • Thyroid Problem |
| • Bone Disorders | • Heart Murmur | • Tuberculosis |
| • Cancer | • Heart Pace Maker | • Weight Loss (unexpected) |
| • Chemotherapy/Radiation | • Hepatitis A, B, C (circle) | • Other _____ |
| • Diabetes | • Herpes Simplex Type I | _____ |

Do you have any health problems that need further clarification? Yes / No

If yes, please explain. _____

To the best of my knowledge and belief, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at my next appointment.

Patient or Parent/Guardian Signature _____ Date _____

Doctor/Hygienist Signature _____ Date _____

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Oral Cancer Screening:

Oral cancer can be detected early at your dentist office. Our office recommends Oral Cancer Screening (OCS) to all adult patients due to the statistical increase of oral cancer cases in the US. Diagnosing oral cancer early is the key to successful treatment before it progresses to a more advanced stage.

Our office performs OCS using Identafi*, a procedure which uses three different wave lengths of light to help detect any suspicious areas in the mouth. It is a painless procedure and takes only about 10 minutes to complete.

The fee for OCS is \$60 which is the patient's responsibility at time of service. Typically, insurance does not cover this procedure; however, our office will file an insurance claim (if applicable) on your behalf. In the event, your policy covers the OCS, any credit on your account can be refunded or can be applied towards future treatments.

It is your decision whether or not to have this procedure. You can discuss this further with Dr. Francisco if you wish during your office visit. However, we ask that you make your initial treatment choice below. Please check the appropriate option(s):

_____ I elect to have an OCS during my initial office visit. Fee is \$60.

_____ I decline to have an OCS during my initial office visit.

Patient or Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

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HIPPA Release:

Regarding release of my dental records including examination, diagnosis, treatment, insurance claim details, ledger details, billing, and payments, I authorize information to be released as follows (check all that apply):

_____ Spouse _____

_____ Child(ren) _____

_____ Parent _____

_____ Other _____

_____ Information is not to be released to anyone

Regarding messages and communications from our office to you concerning matters pertaining to your care, if we are unable to speak directly to you, please select your preferences below:

_____ You may leave a detailed message

_____ Leave a message asking me to return your call

_____ Other _____

Best telephone number is to reach me is _____

Patient or Parent/Guardian Printed Name _____

Patient or Parent/Guardian Signature _____ Date _____

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Acknowledgement of Receipt of Notice of Privacy Practices:

You may refuse to sign this acknowledgment. The Notice of Privacy Practices is located in pdf format on our website (www.EdFranciscoDDS.com) under Patient Forms and is also available in hard copy at the front desk in our office.

I have read/received a copy of the office's Notice of Privacy Practices.

Patient or Parent/Guardian Signature _____ Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Patient refused to sign

_____ Communication could not be made with patient

_____ Emergency situation prevented us from obtaining acknowledgement

_____ Other (specify) _____

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Broken/Missed Appointment Policy:

Our practice strives to see all patients at scheduled appointment times. We respect your time and know you have a busy schedule as well. When an appointment is made, we block time in our schedule specifically for you, and our staff prepares specifically for your appointment. If you are unable to keep your appointment, please be courteous to other patients and our office staff, and notify us at least 24-hours in advance of your appointment time. Note that 24-hour refers to our office business hours which does not include nights, weekends, or holidays.

Our office will assess a fee for broken/missed appointments without 24-hour notice. Fees are as follows:

- \$60.00 – First broken/missed appointment
- \$70.00 – Each additional broken/missed appointment

Thank you in advance for your understanding.

I understand and agree to the above office policy.

Patient or Parent/Guardian Signature _____ Date _____

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Statement of Financial Responsibility and Consent for Services:

PLEASE READ THIS AGREEMENT IN ITS ENTIRETY BEFORE SIGNING.

Thank you for choosing Ed Francisco, DDS, PA as your dental provider. The dental services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding this financial responsibility, we ask that you read and sign this form. Please feel free to ask if you have any questions regarding your financial responsibility.

You are ultimately responsible for all payment obligations arising from your treatment and guarantee payment for these services. As a condition of your treatment by this office, financial arrangements must be made in advance. Payment is due at time of service for services rendered without insurance coverage (self-pay), emergency dental services, or any dental services performed without previous financial arrangements.

For patients with insurance coverage, your insurance policy itemizing your dental benefits is a contract between you, your employer, and your insurance company. Your insurance company pays based upon its interpretation of such policy/contract. Our office is **not** a party to this contract. You are responsible for knowing your insurance policy. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly. It is important to note that dental insurance plans are **not** designed to cover all of your dental needs. You are responsible for deductibles, co-payments, co-insurance amounts, any other patient responsibility as indicated by your insurance carrier, and any other amounts not approved or not paid by your insurance carrier.

Ed Francisco, DDS, PA does not render services under the assumption that our fees will be paid by an insurance company. You receive services under this same assumption. Our office diagnoses and treats based upon a professional assessment of dental necessity and **not** based upon what your insurance contract covers, approves, and/or pays. We will, however, make every attempt to follow your policy guidelines to help maximize the use of your benefits. You are financially responsible for the treatments provided regardless of whether or not your insurance covers a particular service and if covered, whether or not it is actually approved for payment.

Verification of insurance coverage and benefits, it is NOT a guarantee of payment by your insurance company. Your insurance company gives our office NO GUARANTEE of payment for any service rendered even if the service is a covered service under your plan. Therefore, our office can give you NO GUARANTEE of what your actual amount due will be for any service until your insurance actually makes a final determination of payment under the contract (which is after the service is actually rendered). Furthermore, any treatment plan that is proposed for your dental needs is an estimate of cost based on the information provided by your insurance carrier *at that particular time* – again, it is NO GUARANTEE of payment for the services.

If you desire to ascertain a more precise estimate of your costs, a Pre-Determination estimate (Pre-D) can be submitted to your insurance carrier. You must inform our insurance coordinator prior to initiating treatment. This process can take up to two to six weeks. It is important to note that even if an approved Pre-D is obtained from your insurance, it is still NO GUARANTEE of payment. We have had insurance approve treatment on a Pre-D and subsequently, deny the actual claim after the service is rendered.

Regardless of insurance coverage, your initial estimated co-payment is due in full on day of service unless other financial arrangements are made in advance. **If your insurance plan does not pay the remaining claim balance within 90-days of treatment date, you are responsible for the outstanding balance. We will expect payment in full at that time.** You may then seek reimbursement from your insurance carrier. In the event your insurance

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Statement of Financial Responsibility and Consent for Services, continued:

carrier pays more than we estimate for a treatment, we will credit such collection to your account and/or any other account in which you are the financial responsible party, and any remaining credit will be refunded.

You authorize Ed Francisco, DDS, PA to verify your insurance benefits and submit your claim to your insurance carrier or other plan provider. You agree to facilitate payment of claims by contacting your insurance carrier or other plan provider when necessary. Without waiving any obligation to pay, you assign to Ed Francisco, DDS, PA for application onto your bill for services, all of your rights and claims for the dental benefits to which you, or your dependents are entitled.

As a courtesy to you, we will file your claim with your dental insurance carrier for services rendered. In addition, we may appeal any adverse decision made by your insurance after the initial claim is processed. Our decision whether to appeal or not is based upon the nature of the denial and in our judgment, the likelihood of getting a favorable revision of the initial decision.

You are required to comply with all office registration procedures which includes but not limited to updating or verifying personal information, presenting verification of current insurance, providing signatures, and paying any co-pays or other patient responsibility amount at each visit. Your insurance card or other insurance verification must be on file for your insurance to be billed. It is important to notify us as soon as possible of any changes related to your insurance coverage. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance and will reimburse to you any amount paid. If you are not prepared to make your co-pay or other patient responsibility amount, your appointment is subject to being cancelled.

By signing below (via original, copy, facsimile, or electronic signature), I agree to all terms and conditions contained herein and give my consent for services from Ed Francisco, DDS, PA.

Patient or Parent/Guardian Signature _____ Date _____