Dr.Stephanie Lacquaniti, DMD

Acknowledgement of Receipt of Notice of Privacy Practices

I have read or received a copy of this office's Notice of Privacy Practices:

_____

Print Name of Patient

_____

Signature

_____

Date:

Date_____ Who referred you to us? _____

Patient's Name_____ Preferred Name_____
Last First Initial

Mailing Address_____
Street Address or P.O. Box City State Zip

Residence Address_____

Birth Date____/____/_____ Social Security # _____Email_____

Patient Info: ☐ Male ☐ Female ☐ Minor (parent's info please) ☐ Single ☐ Married ☐ Widowed

Patient's Employer _____ Location_____

Spouse's Name _____ Parent's Name (if minor) _____

Any immediate family who is a patient here? ☐ YES ☐ NO If YES, list name(s)_____

## TELEPHONE NUMBERS

| | | | |
|---|---|---|---|
| Patient's Home # | ( ) | Spouse's Work # | ( ) |
| Patient's Cell # | ( ) | Spouse's Cell # | ( ) |
| Patient's Work # | ( ) | Emergency Contact Name | |
| Patient's Other # | ( ) | Emergency Contact # | ( ) |

## DENTAL INSURANCE

**Do you have Dental Insurance?** ☐ YES ☐ NO **If YES, please complete below. Our doctors do not participate in any dental networks (HMO or DMO), therefore your insurance company must allow you to seen an out-of-network provider (PPO).**

**Subscriber (Employee) name/address** _____

**Subscriber's Birth Date** ____/____/_____ **Subscriber's Social Sec. # or I.D. #** _____

**For your insurance to be filed, you must provide an insurance card. If we agree to accept assignment, your deductible and percentage not covered is due at time of treatment. If your insurance does not pay within 30 days, you are responsible for the entire balance and must contact your carrier directly to resolve your claim. I authorize the release of any medical information necessary to process this claim. I authorize payment of benefits directly to Kim P. Karvasale, DMD, if applicable.**

## PAYMENT INFORMATION

**I understand and agree that regardless of my insurance status, I am financially responsible for my account balance for any professional services rendered. Payment of fees may be in CASH, CHECK, MC, VISA or DISCOVER. If my account becomes delinquent, I agree to payment of all collection fees, not excluding or limited to a collection agency, court costs and/or attorney fees. Delinquent accounts are subject to an 18% APR on outstanding balance.**

**Person financially responsible for this account** _____
Name Address Telephone #

**Responsible Party/Patient Signature**_____ **Date**_____
(Parent or Guardian if patient is a minor)

## DENTAL HISTORY

**Previous dentist's name**_____ **Location**_____

**Reason for dental visit**_____ **Last dental visit date**_____

**List any problems with previous dental treatment**_____

**Personal Physician's name**_____ **Telephone #** _____

**Please turn this form over for the MEDICAL HEALTH HISTORY. All information is completely confidential and will be used each time we select the safest and most effective means of providing you with dental care.**

## MEDICAL HISTORY

Please answer YES or NO to the following questions by placing an ✖ in the appropriate box.

| | YES | NO | If YES, please explain all details |
|---|---|---|---|
| Any medical changes in the past year? | | | |
| Are you under physician's care now? | | | |
| Have you experienced bleeding that was difficult to stop? | | | |
| Have you been hospitalized in the past 5 years? | | | |
| Do you take antibiotics prior to dental procedures? | | | For what condition? |
| Do you take blood thinners? | | | Which medication? |
| Do you have any prosthetic joints? | | | Which joint? |
| Do you use tobacco products? | | | Which form? |
| Do you have Hepatitis? | | | Type? |
| Are you reading these questions? | | | ☺ |
| Have you had an organ transplant? | | | Which organ? |
| Women: Are you pregnant? | | | |
| Do you take oral contraceptives? | | | |

Please answer YES or NO if you've had an Allergic Reaction to any of the following by placing an ✖ in the appropriate box.

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Penicillin | | | Latex | | | Codeine | | |
| Aspirin | | | Tylenol | | | Metals | | |
| Acrylic | | | Other: | | | Other: | | |

## CONDITIONS

Please answer YES or NO to the following Conditions by placing an ✖ in the appropriate box.

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Alzheimer's Disease | | | Diabetes | | | Lung Disease | | |
| Anemia | | | Epilepsy | | | Mitral Valve Prolapse | | |
| Arthritis | | | Fainting | | | Pacemaker | | |
| Asthma | | | Glaucoma | | | Prosthetic Heart Valve | | |
| Bypass Surgery | | | Heart Attack | | | Rheumatic Fever | | |
| Cancer Treatment | | | Heart Murmur | | | Sinus Problems | | |
| Chemical Dependency | | | High Blood Pressure | | | Stroke | | |
| Chest Pains | | | HIV/AIDS | | | Tuberculosis | | |
| Cold Sores/Herpes | | | Kidney Problems | | | Ulcers | | |
| Congenital Heart Lesions | | | Liver Disease | | | Venereal Disease | | |

## MEDICATIONS

Please list ALL MEDICATIONS you are taking. If you have a list of medications to copy, please provide it to a member of our staff and ✖ this box ➔ ☐

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Please list anything else that you feel we should know:** _____

_____

**I HAVE READ, UNDERSTOOD AND COMPLETED THIS MEDICAL HISTORY. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.**

**SIGNATURE OF PATIENT, PARENT or GUARDIAN**_____ DATE_____

LACQUANITI DENTAL, LLC Temp: _____

**COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM**

I, _____, **knowingly and willingly consent to have dental treatment completed during the COVID-19 Pandemic.**

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

Dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit COVID-19 virus.

I confirm that I am NOT presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of breath
- Loss of sense of taste or smell
- Dry cough
- Runny nose
- Sore Throat
- _____ ***(Initials)***

I understand air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least six (6) feet for a period of fourteen (14) days to anyone who has, and this is not possible with dentistry. _____ ***(Initials)***

- I verify that I have NOT traveled internationally (outside the United States) by commercial airline within the past ten (10) days. _____ ***(Initials)***

Signature_____

Print Name _____ Date_____