JOHN L. LIPANI, DMD – DAVID A. LIPANI, DMD LLC

We are pleased you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? _____

Patient Information

Date_____ Patient's Name _____
Last First Middle
Address _____
Street Unit# City State Zip
Home Ph.# (_____) _____ Work Ph.# (_____)_____ Cell Ph.# (_____)_____
Soc. Sec. # _____-_____-_____ Drivers. Lic. # _____ E-Mail _____
Birthdate ____/____/____ Sex M F If patient is a minor, give parent's or guardian's name _____
Emergency Contact _____ Ph. # (_____) _____

Responsible Party Information

Name_____
Last First Middle Marital Status
Soc. Sec. #_____-_____-_____ Birthdate ____/____/____ Relationship to Patient_____
Residence _____
Street Unit.# City State Zip
Mailing Address _____
Street City State Zip
Home Ph. # (____) _____ Work Ph. # (____) _____ Cell Ph. # (____) _____ Fax (____) _____
Spouse's Name _____ Relationship to Patient _____
Soc. Sec. #_____-_____-_____ Birthdate_____/____/____ Work Ph.# (____)_____
Employer _____ Occupation_____ No. Years Employed_____
Employer Address_____

Insurance Information

Primary Insurance Company_____ Ph.# (____)_____ Group # _____
Insured's Name _____ Insured's Soc. Sec.# _____-____-_____ Insured's DOB ___/___/____
Is the policy connected with your union? YES NO Name of Union_____ Local #_____
Do you have dual coverage? YES NO If yes: Please complete the following secondary insurance information:
Secondary Insurance Company_____ Ph.# (____)_____ Group# _____
Insured's Name _____ Insured's Soc. Sec #_____-_____-_____ Insured's DOB ___/___/____

Dental Information

Do your gums bleed when you brush? YES NO
Are your teeth sensitive to heat or cold? YES NO Pressure? YES NO Sweets? YES NO
Do you grind or clench your teeth? YES NO
Do you have any fear of dental work? YES NO
Date of last dental visit _____ What was done at that time? _____
Former Dentist Name_____ City _____
How would you describe your current dental problem? _____
_____
How do you feel about the appearance of your teeth? _____

Medical Information

1. Are you having pain or discomfort at this time?_____ YES NO
2. Have you been a patient in the hospital during the last two years? _____ YES NO
3. Are you now taking any medications or drugs? _____ YES NO
   If yes, please list:_____
4. Have you ever taken FOSOMAX or any bisphosphonate medication ? _____ YES NO
5. Have you taken any medications or drugs during the last two years? _____ YES NO
6. Have you been under the care of a medical doctor during the last five years?_____ YES NO
   Physician's Name _____ Ph.#_____
   Address_____
7. Are you allergic to any medications or anesthetics? _____ YES NO

8. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Heart Failure_____ YES NO	Artificial joints (hip, knee, etc.)___ YES NO	Hepatitis _____ YES NO
Heart Disease or Attack ____YES NO	Kidney Trouble _____ YES NO	If yes which strain? A B C
Angina Pectoris_____YES NO	Ulcers _____YES NO	Venereal Disease_____ YES NO
Congenital Heart Disease __ YES NO	Diabetes _____YES NO	A.I.D.S. _____ YES NO
Heart Murmur_____ YES NO	Thyroid Problems _____ YES NO	H.I.V. Positive _____YES NO
High Blood Pressure_____ YES NO	Glaucoma _____ YES NO	Cold Sores/Fever Blisters _ YES NO
Arteriosclerosis _____ YES NO	Cancer _____ YES NO	Blood Transfusion_____ YES NO
Mitral Valve Prolapse _____ YES NO	Emphysema _____ YES NO	Hemophilia _____ YES NO
Artificial Heart Valve _____ YES NO	Chronic Cough _____ YES NO	Anemia _____ YES NO
Heart Pacemaker _____ YES NO	Tuberculosis _____ YES NO	Sickle Cell Disease _____ YES NO
Heart Surgery _____YES NO	Asthma _____ YES NO	Bruise Easily _____ YES NO
Rheumatic Fever _____ YES NO	Hay Fever _____ YES NO	Liver Disease _____ YES NO
Arthritis _____ YES NO	Allergies or Hives _____ YES NO	Yellow Jaundice_____YES NO
Rheumatism _____ YES NO	Sinus Trouble _____ YES NO	Epilepsy or Seizures_____YES NO
Cortisone Medicine _____ YES NO	Radiation Therapy _____ YES NO	Fainting or Dizzy Spells __ YES NO
Drug Addiction _____ YES NO	Chemotherapy _____ YES NO	Nervousness _____ YES NO
Stroke _____ YES NO	Developmentally Disabled _____ YES NO	Tumors _____ YES NO
Allergy to Latex _____YES NO	Allergy to Metal (Jewelery,etc.) ___YES NO	Osteoporosis _____ YES NO

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? _____ YES NO
10. Do your ankles swell during the day? _____ YES NO
11. Have you lost or gained more than ten pounds in the last year? _____YES NO
12. Did you ever wake up from sleep and feel short of breath? _____ YES NO
13. Are you on a special diet? _____ YES NO
14. Do you have or have you had any disease, condition, or problem not listed? _____ YES NO
    If yes, please list: _____

FOR WOMEN ONLY:
Are you pregnant? YES NO What month? ____ Are you nursing? YES NO Are you taking birth control pills? YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date_____

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1- 1.5 finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that it is my responsibility to advise this office of any changes in the information obtained on this form.
5. I authorize the use of my social security number to file my dental claim.

Patient Signature _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____

Financial Policy

We are pleased you have chosen us to address your dental concerns. Our primary goal is to restore, preserve, and protect your dental health.

If you have a dental benefit plan, we will be happy to assist in filing your claim for service. You as the insured, however, are responsible for understanding your plan parameters and coverage. Most benefit plans offer only partial coverage and have a yearly maximum. Payment of fees is ultimately the responsibility of the patient

Payment is due when services are rendered. In addition to cash and personal checks, we do accept credit cards for your convenience. If a payment plan is needed, we offer CareCredit® as an extended payment option.

Patients with accounts in arrears may be referred to a collection agency, and will be responsible for any collection agency fees, and or court costs in addition to the outstanding balance.

Please sign below to indicate that you understand and agree to the above stated policy.

Responsible Party's Signature _____

Please Print Your Name _____

Guarantor For _____

Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

This form is available on our website or at our front desk for your review. You may refuse to sign this acknowledgement

I, (*please print your name*)_____ have received a copy of this office's Notice of Privacy Practices

Signature_____ Date_____

----------For office Use Only----------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could no be obtained because:

Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgement ☐

An emergency situation prevented us from obtaining acknowledgement ☐ Other ☐ _____

Authorization for Signature on File

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance claims. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges regardless of insurance coverage.

Please Print Your Name _____Signature _____

Date _____