Josie Dovidio DDS
Gentle Family Dentistry

Patient Information

Last: _____

First: _____MI: _____

Street: _____

City: _____ Zip:_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Sex: ____M ____F Age: _____

Date of Birth: _____

Patient's SSN: _____

Employer (or School): _____

Occupation (or Grade): _____

Spouse, Parent or Guardian Info

Spouse (or Parent's) Name:

_____

Spouse (or Parent's) Date of Birth: _____

In case of Emergency Phone # _____

Spouse (or Parent's) Employer: _____

Occupation: _____

Account Information

How will you settle your account today?

____Cash ____Check ____Credit Card

____ CareCredit

Do you participate in a Health Savings or Flex Spending Account? _____Yes _____No

_____

Dental Insurance #1: _____

Insurance's Phone #: _____

Subscriber Name: _____

Subscriber SSN or ID #: _____

Subscriber Birth Date: _____

_____

Dental Insurance #2: _____

Insurance's Phone #: _____

Subscriber Name: _____

Subscriber SSN or ID #: _____

Subscriber Birth Date: _____

So we may better serve you, Please answer the following questions.

What is the major purpose of this visit?

Are there specific dental concerns you want to discuss today?

How were you referred to our office?

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Financial Policy

Many of us don't think about it, but the cost of collecting payments from patients who have not paid them by the specified due date is substantial. In an effort to curb overhead costs and avoid higher fees to you, the following policy has been established. We ask that patients pay for their treatment, at the time of service, with any of the following options:

Cash

Check: personal check, cashier's check or money order

Credit Cards: Visa, MasterCard or American Express

CareCredit: Third party financing (ask us for more information)

Insurance: We will be glad to bill your insurance company, on your behalf, for treatment provided. Estimated co-payments will be presented to you at the time your treatment is planned and discussed. You are responsible for any portion of fees not covered by your insurance company.

Please initial each statement

____ Payment in full for procedures completed at each visit. ***If insurance is involved***, then all deductibles and estimated co-payments will be collected at each visit, as per the terms of your policy.

____ A **monthly late charge of 1.5%** of the account balance will be applied to all delinquent payments. Balances are due by the specified date on your statement and will be considered delinquent within 60 days of the date of service. If the account goes into collection activity, the patient will be responsible for any filing costs, collection fees, court and attorney fees. *No charges apply to on-time payments.*

_____ **Returned Check Fee:** Patients who write checks that are returned for "insufficient funds" will be responsible for the amount of the check and a service charge of $25 for the first check and $35 per check for each subsequent check that is returned. The fees are compliant with California Check Law.

_____ **Broken Appointment Fee:** Appointments are reserved especially for you. Kindly give our office 48-hour notice if you need to reschedule or cancel. That gives us enough time to notify patients who are waiting for your appointment time. A $50.00 fee will be considered if a 48-hour notice is not given.

_____ **X-ray Duplication Fee:** There is no charge for emailing digital x-rays to your new dentist. However, if your new dentist requires a hard copy of your x-rays, a $20.00 fee will be charged to cover the cost of duplication.

We thank you for your prompt payment. Adherence to this policy will help us to continue to providing affordable dental care. We look forward to serving you and your family's dental health needs for many years to come. ***By signing below, I hereby certify that I have read and understood this financial policy and I can request a copy of it at any time.***

Patient's Signature _____ **Date** _____

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Dental Insurance
Authorization to Submit Claims

We will gladly bill your insurance company on your behalf. Dental plans can vary from employer to employer, with different procedures being covered or not covered. Insurance companies base the amounts they will pay on a restricted fee schedule that relates to premium payments and geographical location. In other words, your insurance plan will pay only what is allowed for each service, regardless of what the actual fee might be.

Please initial each statement below:

____ Regardless of insurance involvement, by law, you are financially responsible for all services rendered. We bill your insurance carrier solely as a courtesy to you.

____ You will inform our office if there are any changes with your insurance.

____ As a courtesy, we verify eligibility and benefits with your insurance carrier. Please understand they begin with a "disclaimer" that the information they are providing to us is not a guarantee of payment.

____ Estimated co-payments and deductibles are built into most plans and their required payment is strictly regulated by state law. Therefore, all deductibles and estimated co-payments will be collected at each visit, as per the terms of your policy.

____ Because your policy is a contract between you, your employer and your insurance company, we cannot be held responsible for collecting your claim. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay. If necessary, we will re-submit your claim a second time within a 60-day period. If your insurance fails to pay in 60 days, we are left with no option but to turn over the balance to you for payment. Any further follow up for reimbursement from the insurance company will be your responsibility.

____ Some insurance plans reimburse patients directly. For those types of plans, payment in full will be required at the time of service.

____ If an insurance payment is made directly to you for services billed by us, you recognize the obligation to promptly remit that payment to Josie Dovidio, DDS.

____ 48-hour notice is required for all cancellations. If any appointment is missed with less than 48 hour notice you will be subject to a $50 fee which is not covered by insurance.

Authorization for Signature on File

I hereby authorize any of the dentists listed above to affix my name to any and all claims or documents related to treatment received in this office. I also authorize the release of any information regarding my medical or dental history, and treatment, for the purpose of validating and determining benefits payable in connection with insurance claims. I hereby authorize payment of dental benefits, otherwise payable to me, directly to the office listed above. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges.

Signature _____ Date _____

Josie Dovidio DDS
Gentle Family Dentistry

JOSIE DOVIDIO, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Josie Dovidio DDS
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Patient's Name _____ Date _____

MEDICAL HISTORY

Are you currently under the care of a physician? YES NO
If yes, please explain:

Date of last physical examination _____/_____/_____

Physician's Name _____ Phone (_____)_____

City _____

Have you ever had a serious illness, operation, or been hospitalized? YES NO
If yes, please explain:

Has there been any change in your health in the last two (2) years? YES NO
If yes, please explain:

Have you ever had or been treated for (circle all that apply):

Acid Reflux	Drug Addiction	Mental Health Disorders
AIDS / HIV	Eating Disorder	Mitral Valve Prolapse
Anxiety	Fibromyalgia	Osteoporosis
Arthritis	Headaches / Migraines	Pacemaker
Asthma	Hepatitis	Radiation Therapy
Autoimmune Disorders	High Blood Pressure	Seizure Disorder
Bleeding / Clotting Disorders	High Cholesterol	Sexually Transmitted Disease
Cancer	Heart Attack	Sinus Problems
Chemotherapy	Heart Disease	Stroke
Chest Pain	Heart Murmur	Thyroid Problems
Cold / Canker Sores	Heart Valve Replacement	Tuberculosis
Coronary Artery Disease	Herpes	Ulcers
Depression	Joint Replacement	Other:
Diabetes	Kidney Problems	

How many alcoholic drinks do you consume a day? _____ a week? _____ a month?_____

Do you now or have you ever used tobacco? YES NO
If yes, in what form? (cigarettes, chewing tobacco, cigars)

Have you ever had an allergic reaction to (circle all that apply):

Aspirin	Latex Products	Penicillin	Other:
Codeine	Local Anesthetic	Seasonal Allergies	
Food	Metals (Nickle, etc.)	Sulfa	

For Women:
Are you pregnant or do you think you may be pregnant? YES NO
If yes, how many weeks? _____
Are you nursing? YES NO
Are you taking birth control pills? YES NO

Have you ever taken, or are you scheduled to take (circle all that apply):

Pondimin (fenfluramine)	Fosamax (alendronate)	Boniva (ibandronate)
Redux (dexphenfluramine)	Actonel (riderdronate)	Aredia (pamidronate)
Phen-Fen	Zometa or Reclast (zoledronic acid)	

Have you ever been told to pre-medicate (take antibiotics) prior to dental procedures? YES NO
By whom and for what reason?

Current Medications: *(include dose and frequency)*

Do you have any disease, condition or problem not listed above? Please explain:

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromising situation, medical consultation may be needed prior to starting any dental treatment. Since my dentist and staff will rely on this health history for treating me, I will not hold them responsible for any action they take, or do not take, because of errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

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Patient's Name _____ Date _____

DENTAL HISTORY

1. Reason for today's visit: *(circle all that apply)*

   Examination Cleaning Pain Swelling Broken Tooth or Filling Cosmetic Concerns

   Other:

2. Approximate date of last dental examination and cleaning? _____/_____/_____
3. Approximate date of last dental x-rays? _____/_____/_____
4. Do your gums bleed when you brush or floss? YES NO
5. Have you ever had a "deep cleaning"? YES NO
6. Have you ever been told you have gum disease? YES NO
7. Do you experience dry mouth? YES NO
8. Have you ever been told you have bad breath? YES NO
9. Are your teeth sensitive to? *(circle all that apply)* Sweets Cold Heat Pressure None
10. Have you ever had any of the following with your jaw joints? *(circle all that apply)*

    Clicking Popping Discomfort Lock Jaw
11. Do you clench or grind your teeth? YES NO
12. Do you have a strong gag reflex? YES NO
13. What would you like to change about the present condition of your mouth?

14. Are you happy with your smile? YES NO (If no, please explain below)

15. Is there anything about your former dentist or previous dental experiences that we should be aware of ?

To the best of my knowledge, the answers I have given are accurate. I understand it is very important to report any changes in my medical or dental status.

Patient Signature_____ Date _____
(if patient is a minor, parent's signature is required)