Health History

Name _____ Date _____

Date of last health care exam: _____ What was this exam for: _____

Have you been hospitalized in the last 5 years? (please circle) No Yes

If yes, reason: _____

Are you currently receiving medical care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the dentists and physicians who are providing care for you:

1. General Dentist: _____
2. Primary Care MD: _____
3. Specialist MD: _____
4. _____

For the following questions, please circle yes or no. Your answers are for our records only and will be confidential. Please note that our team may ask additional questions concerning your health in order to optimize your care.

Anemia or Blood Disorder	No	Yes	Hepatitis, any form	No	Yes
Diabetes—Type I or Type II Last HbA_1C- date value	No	Yes	Liver disease	No	Yes
Asthma Been hospitalized for condition?	No No	Yes Yes	Joint replacement- what joint _____ When placed?	No	Yes
COPD or other lung disease	No	Yes	HIV infection / AIDS or ARC	No	Yes
Abnormal bleeding	No	Yes	Kidney disease	No	Yes
Epilepsy, Seizure, fainting spells	No	Yes	Psychiatric Care	No	Yes
Abnormal Heart Beat	No	Yes	Stroke	No	Yes
Heart disease, Heart attack, and/or Heart surgery	No	Yes	Cancer or tumor Radiation or Chemotherapy	No	Yes
Heart stent when placed?	No	Yes	Glaucoma	No	Yes
Heart murmur, heart valve disease	No	Yes	Rheumatic fever	No	Yes
Heart and/or valve replacement	No	Yes	Recurrent sinus infections	No	Yes
Previous Bacterial Endocarditis	No	Yes	Slow healing mouth sores	No	Yes
Arthritis, Rheumatism, Inflammatory disease	No	Yes	Other conditions	No	Yes

Abnormal Blood Pressure? (please circle) No Yes What is your normal blood pressure?: _____
Today (in office): BP _____ HR _____

Medications/Reason for use:

Please list any medications (prescription and over-the-counter) you are currently taking, include any medication patches and meds for smoking cessation:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list any dietary or herbal supplements you are taking and for what purpose:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

OFFICE FINANCIAL POLICY

It is our policy to discuss treatment plans with all patients or guardians before dental treatment is started. A complete estimate of fees and method of payment will be discussed after the initial consultation.

Dental Insurance:

This office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to the benefits provided. Dental insurance is a contract between the patient and the insurance company.

To prevent any misunderstanding concerning dental insurance payment, the following policy has been established:

1.) Payment must be made as treatment progresses and surgery must be paid in full one week prior to your scheduled date.
2.) We will complete and mail your insurance forms for you. Please keep in mind, however, that you are responsible for payment for services rendered.
3.) A pre-estimate form can be submitted to your insurance company for authorization of benefits prior to treatment being started. Keep in mind that these take 4-6 weeks for a reply from most insurance companies.

PLEASE NOTE:
Predeterminations are not a guarantee of payment. It is the patient's responsiblility to know how much of their yearly benefit is remaining for the year. Most insurance companies have web sites for your convenience to access what benefits you have used and have left for the year.

Method of Payment:

1.) Full payment at each appointment is expected in the form of cash, check, credit card (Visa, MasterCard, Discover, Debit, American Express or Care Credit)
2.) If you would need to make payment arrangements, please see our front desk for information on financing through Care Credit.
3.) Interest charges of 1.5% per month are placed on the account if payment is sixty (60) days past due.

Cancellation Policy:

THERE WILL BE A $250.00 CHARGE FOR ANY SURGICAL APPOINTMENT CANCELLED WITHOUT ONE (1) WEEKS NOTICE. THERE WILL BE A $50.00 CHARGE FOR ANY HYGIENE APPOINTMENT CANCELLED WITHOUT 48 HOUR NOTICE.

I have read and understand my financial responsibility at RocPerio & Implants *If my account goes past due 90 days, I understand that I will be responsible for any charges associated with collection proceedings.*

Patient Signature: _____ Date: _____

RocPerio & Implants
2109 S. Clinton Ave. Suite 200
Rochester, NY 14618
585-756-5566

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

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

Print Name:_____

Signature:_____

Date:_____

The following person(s) may receive information regarding my protected patient information:

_____

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 2109 S. Clinton Ave. Suite 200 Rochester, NY 14618. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.
I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
This authorization expires on the following date, or when the following event occurs: _____

Below this line-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)