PATIENT REGISTRATION AND MEDICAL HISTORY

DATE_____ (PLEASE PRINT)

Patient _____
Last Name First Name Initial "Nickname"

Street Address _____ City_____ State_____ Zip_____

Phone : Home(___) _____ Work (___) _____ Cell (___)_____

Sex ☐ M ☐ F Birthdate _____ ☐ Single☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____ Occupation_____ Email_____

Business Address _____ Patient S.S. # _____

Spouse Name _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

In case of emergency, who should be notified? _____ Phone (___) _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

MEDICAL HISTORY

Physician Name _____ Phone _____ Date of Last Physical _____

Address _____ City/State _____ Zip _____

Date of Last Dental Exam _____ Date of Last Dental X-rays _____

Have you ever had any of the following?

Y	N		Y	N		Y	N	
☐	☐	Physician Recommended Antibiotics Prior to Dental Treatment Dr's Name _____	☐	☐	Asthma	☐	☐	High Cholesterol
			☐	☐	Bleeding Problems	☐	☐	HIV / AIDS
			☐	☐	Blood Transfusion Date_____	☐	☐	Latex Allergy
☐	☐	Mitral Valve Prolapse	☐	☐	Cancer _____ Date_____	☐	☐	Mental Health Disorders
☐	☐	Joint Replacement: hip/knee/ other Date _____	☐	☐	Chemotherapy/Radiation Treatment			Specify _____
			☐	☐	Cigarettes/Cigars/Chewing Tobacco	☐	☐	Metal Allergy
☐	☐	Rheumatic Fever	☐	☐	Diabetes	☐	☐	Migraines/ Severe Headaches
☐	☐	Heart Murmur		☐	Type I (insulin dependent)	☐	☐	Nervous / Anxiety Problems
☐	☐	Pacemaker/Heart Valve Replacement		☐	Type II	☐	☐	Persistent Swollen Neck Gland
☐	☐	High / Low Blood Pressure (Circle)	☐	☐	Eating Disorder Specify _____	☐	☐	Rapid Weight Loss
☐	☐	Heart Problems/ Heart Attack _____	☐	☐	Epilepsy/ Seizure Disorders	☐	☐	Sexually Transmitted Disease
☐	☐	Alcohol/ Drug Dependency	☐	☐	Fainting Spells			_____
☐	☐	Allergies to Local Anesthetics	☐	☐	General Allergies	☐	☐	Sinus Problems
☐	☐	Allergy:Aspirin/Penicillin/Codeine(circle)	☐	☐	GI Problems-GE Reflux / Ulcer	☐	☐	Sleep Disorder
☐	☐	Antidepressant Medications	☐	☐	Hemophilia	☐	☐	Stroke
☐	☐	Arthritis	☐	☐	Hepatitis __/Jaundice/Liver Disease (circle)	☐	☐	Tuberculosis/Persistant Cough

Have you had an allergic or adverse reaction to medication? List: _____

_____

Have you ever responded adversely to medical or dental treatment? _____

List all medications taken routinely or "as needed" _____

_____

Are you under the care of a physician? For what conditions? _____

Do you suspect that you are pregnant? ☐ Yes ☐ No Taking Birth Control Pills ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

How do you feel about the appearance of your teeth? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled, I will not hold my dentist or any member of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

Date _____ Signature _____

Venneri Dental
3040 E. County Line Road
Hatboro, PA 19040
Phone: 215-675-4090 Fax: 215-675-9059

Financial Responsibility Policy

As a result of the many different and confusing insurance company reimbursement policies, it is necessary to have an easily understood financial responsibility policy.

- It is important for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service. **At each office visit** we need you to show us your insurance card to insure that your current insurance information is on file.

- As a service to our patients, we will submit your insurance claim to your primary insurance company. Our office will provide the insurance company with all the information necessary to help you receive maximum benefit from your insurance company. However, it is the patient's responsibility to know the insurance coverage and benefits limit of their particular policy.

- If a claim is denied, we will research why the rejection occurred and either resubmit to insurance or bill you the appropriate balance. If the claim is denied a second time, the appropriate balance immediately becomes the responsibility of the patient and should be paid to us directly. You may then contact your insurance company for reimbursement.

- If the patient has coverage with a second insurance company, it will be their responsibility to submit to the secondary insurance company. As a service to our patient we will provide you with the secondary claim form along with a copy of the explanation of benefits from the primary insurance. Benefits from the secondary insurance coverage will be paid directly to the patient.

- Insurance is a patient's benefit designed to assist the patient in their financial obligation to the office of Venneri Dental. The patient is the one receiving the dental service and therefore is ultimately responsible for all charges on the account regardless of any insurance coverage. This applies to everyone in the family who is treated in the office of Venneri Dental.

- The office will collect the patient's deductible and the estimated balance after the primary insurance payment at the time of service. After the primary insurance payment is received, the patient will be billed for any difference between the anticipated insurance payment and the actual insurance payment. If the insurance payment is greater than the estimation, we will either refund the amount to the patient or leave the credit balance on the patient's account to be applied toward future treatment.

- In the event that the patient does not have insurance coverage, charges for services are due and payable at the time services are rendered, unless a signed financial agreement has been approved.

Composite (white) fillings are often the choice of treatment to restore a tooth. Some employers have chosen a dental insurance plan which may pay partial or no benefits for these types of restorations. If you need to decline white fillings you must directly inform the doctors prior to treatment.

Insurance benefits are estimates only. I understand that I am responsible for any co-payments and deductibles, along with any procedures that my insurance company does not cover. I authorize the dentist to release any information, including diagnosis and records of treatment rendered to my family, or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that of my dependents. I am also responsible for any insurance claims not paid within 60 days of service.

_____ _____

Signature of Patient (parent if minor) or Responsible Party Date

EFFECTIVE OCTOBER 1, 2019

"NO SHOW AND CANCELLATION" POLICY & PROCEDURE

At The Venneri Dental Group P.C., our goal is to provide quality care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of care. The following policy is with regard to patients who fail to keep their scheduled office visit appointment. We ask that you please be considerate and call The Venneri Dental Group promptly if you are unable to attend your appointment. Available appointments are in high demand. Giving us adequate notice allows us to reallocate this time to someone who is in urgent need of treatment.

- PATIENTS who fail to show for their scheduled appointment or did not notify the office within 48 hours in advance of their scheduled appointment will be subject to a "No Show" or "Cancellation" fee of $33.00. If it is an extended time appointment the cancellation fee is $60.00. *In the event of an actual emergency where prior notice could not be given, a one-time exception may be given.

**THESE FEES ARE NOT COVERED BY INSURANCE AND IS THEREFORE THE SOLE RESPONSIBILITY OF THE PATIENT.

TO CANCEL OR RESCHEDULE AN APPOINTMENT YOU MUST CALL THE VENNERI DENTAL GROUP AT 215-675-4090 DURING BUSINESS HOURS.

_____ _____

Patient Printed name Date

_____

Patient signature

VENNERI DENTAL GROUP, P.C.
3040 E. COUNTY LINE ROAD
HATBORO, PA 19040
(215) 675-4090

Notice of Privacy Practices
Patient Acknowledgment

Patient Name _____ Date of Birth_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of (patient): _____