THE GREENWICH VILLAGE DENTIST

Charles E. Puglisi, DMD., F.A.G.D.
39 Fifth Avenue.
New York, NY 10003

# Your General Information & Preferences

To help us provide proper dental care, please answer the following questions. Your complete answers are vital for us to provide the best treatment possible and to avoid any adverse treatment results. Your answers are for our records only and will be considered confidential. You will have the opportunity to speak privately with Dr. Puglisi about any other concerns or information you may want to share.

Todays Date: _____/_____/_____

## Personal:

Last Name:_____

First Name:_____

Middle Name or Initial:_____

Gender: M / F / T

Birth-date: _____/_____/_____ (month/day/year)

Social Security Number:___-___-____

Marital Status:_____(Married, Single, Significant Other, Complicated)

StreetAddress:_____

City:_____ State:_____ Zip:_____

Email:_____@_____._____

Would you prefer to be addressed by your first or last name? first____ last ____

Gender pronoun preference: __he/him/his __she/her/hers __they/them/theirs

Emergency Contact:_____

Relationship:_____Phone:_____-_____-_____

For whom may we thank for your referral? _____

## Prefered Appointment Times:

Days of the Week _____ Mornings __ Afternoons __ Evenings__

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## Your Dental Health Information

Reason for today's visit? _____

Are you in pain? _____No _____Yes

Please describe: _____

When was your last dental visit?_____/_____/_____ (01/22/2020)

Previous dentists' name:_____phone:_____-_____-_____

How often did you make regular dental visits?_____

What was done at that time?_____

Date of last dental X-rays: _____/_____/_____

Do you feel anxious or apprehensive about today's visit?

____No ____Somewhat ____Quite a bit ____Extremely

- Are you familiar with the term preventative dentistry? _____No _____Yes
- How important are your teeth to you? ___Very ___Somewhat ___Indifferent ___Not at All
- How often do you brush? _____
- How often do you floss? _____
- What type of toothbrush do you use? ___ Soft ___Medium ___ Hard ___Nylon ___Natural
- Do you use mouthwash? _____No _____Yes: Brand_____
- In general how do your gums feel? ___Sore? ___Tender? ___Puffy? ___Swollen?
- Do your gums bleed when brushing? _____No _____Yes
- Do your gums bleed when flossing? _____No _____Yes
- Do you ever feel that your breath is offensive at times? _____No _____Yes
- Are you a mouth breather? _____No _____Yes
- Have you ever been told you need Periodontal (gum) surgery? _____No _____Yes
- Do you experience dry mouth? _____No _____Yes
- Does food get caught between your teeth? _____No _____Yes

  Food Type_____ Where, what area?_____(lower, upper, right, left, front)
- Do you have tooth sesitivity to ___Hot? ___Cold? ___Sweets? ___Biting Pressure? ___None
- Do you avoid chewing in any area of your mouth? _____No _____Yes

  What area?_____

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## Dental Health Information (cont.)

- Have you ever had orthodontics (braces)? _____No _____Yes
- Have you ever been told you needed orthodontics (braces)? _____No _____Yes
- Do you clench or grind your teeth while sleeping or while awake? _____No _____Yes
- Does your jaw ever "pop", causing discomfort? _____No _____Yes
- Do you frequently have aches in your ___head? ___neck? ___shoulders? ___jaw?
- Have you ever had severe trauma to your head, neck, or jaw? _____No _____Yes

  Please explain:_____
- Have you ever used or have been told to use a night guard? _____No _____Yes
- Have you lost any teeth? _____No _____Yes
- Have they been replaced? _____No _____Yes
- How have your teeth been replaced?

  _____fixed bridge _____ removable bridge _____complete denture _____implants
- Are you pleased with the results and would you like to know more about dental options and alternate replacements? _____No _____Yes
- Do you have any chipped, shifted, broken or discolored teeth? _____No _____Yes
- Does the appearance of your teeth and smile please you? _____No _____Yes
- Would you like to know more about various cosmetic proceedures such as bleaching, bonding, tooth recontouring or porcelan veneers? _____No _____Yes
- Have you ever had any problems, complications, or unpleasant experiences with previous dental treatment? _____No _____Yes
- Are there any other issues or concerns that you would like to share? _____No _____Yes

To the best of my knowledge, all of the information I have provided is accurate and correct.
I agree that if I ever have any change to my health I will inform Dr.Puglisi's office ass soon as possible and, certainly no later than my next appointment and treatment. I also understand that I am responsible for all fees for dental treatment provided during this visit and all future visits.

Signature:_____

Date:_____/_____/_____

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## Your General Health Information

Are you generally in good health? ___No ___ Yes

Are you currently under the care of a physician? ___No ___ Yes

Physician's Name:_____ Phone: _____

Last Physical Exam Date:_____/_____/_____ Not Sure:_____

Have you had a serious illness, operation or have you been hospitalized in the last five years? ___No ___ Yes, please explain: _____

Are you alergic to Penicillin? ___No ___ Yes

Are you alergic to Latex? ___No ___ Yes

Are you allergic to any other antibiotics, anesthetics, drugs, foods.

___No ___ Yes, please list: _____

Do you require premedication with antibiotics for dental or medical proceedures?

___No ___ Yes, please list:_____

Have you ever taken the weight loss medication Phen-Phen? ___No ___ Yes

Have you taken Actonel, Zometa, Fosamax or Boniva? ___No ___ Yes

Do you take birth control? ___No ___ Yes, please describe_____

Are you or do you think you might be pregnant? ___ No ___ Yes

Are you Nursing? ___No ___ Yes

Do you take any hormone therapy? ___No ___ Yes

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## Your Medications

Prescribed medications: _____

Non-prescribed medications: _____

Over the counter medications: _____

Dietary supliments or natural remidies:_____

## Your Health History

*Please check if any of the conditions or diseases apply to you.*

- ☐ I smoke or chew tobacco?
- ☐ I consume alcohol?
- ☐ I occasionally use recreational drugs?
- ☐ I have alcohol or drug dependence?

- ☐ I have had a heart attack
- ☐ I have had angina
- ☐ I have a pacemaker
- ☐ I have had heart lesions
- ☐ I have had Rheumatic Fever
- ☐ I have had Heart Valve defects or replacement
- ☐ I have had mitral valve prolapse
- ☐ I have heart murmur
- ☐ I have high or low blood pressure

- ☐ Difficulty swallowing, vomiting or nausea
- ☐ Stomach problems such as ulcers, esophageal hernia or gastric reflux
- ☐ Diarrhea, constipation, blood in stool

- ☐ Asthma, TB, Emphysema, lung disease, persistent cough, coughing up blood

- ☐ Diabetes
- ☐ Excessive urination or thirst
- ☐ Family history of heart disease, diabetes, shortness of breath, swollen ankles

- ☐ Sinus Problems - Disease, Hay Fever

- ☐ Kidney, bladder problems or disease

- ☐ Thyroid, adrenal problems or disease

- ☐ Fainting, epilepsy or seizures

- ☐ Neurological disorders, stroke, ITA
- ☐ Hardening of arteries
- ☐ Problems with mental health, anxiety, depression

- ☐ Liver problems, jaundice, hepatitis

- ☐ Anemia or other blood problems
- ☐ Excessive bleeding,bruise easily, blood transfusions

- ☐ Sexually transmitted disease
- ☐ AIDS or HIV

- ☐ I have or have had tumors or cancer
- ☐ I am undergoing radiation treatments
- ☐ I am undergoing chemotherapy

- ☐ Problems with immune system
- ☐ Persistent swollen glands
- ☐ Arthritis, rheumatism

- ☐ Artificial joints or prosthetics
- ☐ Implants, breast, facial, or other

- ☐ Eye disease, glaucoma
- ☐ Do you wear contact lenses?

- ☐ Hearing problems, ringing in ears
- ☐ Eating disorders

- ☐ Sleep apnea or daytime sleepiness

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# Dental Treatment Consent Form

*Please read and initial the items below and sign the section at the bottom of form.*

1. X-rays (initial) _____

2. Drugs and Medications
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and /or anaphylactic shock (severe allergic reaction.)
(Initial) _____

3. Changes In Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to Dr.Puglisi to make any and all changes and additions as necessary (initial) _____

- I understand that dentistry is not an exact science and therefore, reputable practitioners cannot fully guarantee results.
- I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.
- I have had the opportunity to read this form and ask questions.
- My questions have been answered to my satisfaction. I consent to proposed treatment.

Signature of Patient:

_____ Date:_____

Signature of Parent or Guardian (if patient is a minor)

_____ Date:_____

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# Notice of Privacy Practices

*HIPPA Privacy Form 1*

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically.

We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them.

We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice.

Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions.

Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice.

We must also post the revised Notice in our office as discussed above.

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## Acknowledgement of Recipt of Notice of Privacy Practices

*You may refuse to sign this form if you wish.*

I,_____ ,

(Please Print Name)

have received a copy of this office's Notice of Privacy Practices. I have read it thoroughly and underatand its contents.

X _____

(Signature)

_____/_____/_____

(Date)

### For Office Use Only

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)_____

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# Pre-authorization Payment Form

***Please complete before your first visit and update payment information as it changes.***

Dear Patient:

In an effort to provide you with quality dental care and flexible payment arrangements, we have expanded our payment policy. Payment arrangements are requested by the time of your first visit. We now offer the following payment options:

- Payment by cash
- Automatic monthly billing to your Credit Card or Debit Card
- Guarantee your insurance co-payments with Credit Card or Debit Card

## Credit Card Information

Please complete information below and return to our office before your visit.

Name on Card: _____

Card Type: VISA | MASTERCARD | DISCOVER | AMERICAN EXPRESS

Account Number: _____-_____-_____-_____

Exp. Date _____/_____ Security Code _____ Billing Zip code _____

Cardholder Signature _____

Date: _____/_____/_____

**For Our Patients Using VISA/MASTERCARD:**
Our office is a fully approved and accredited user of the VISA/MASTERCARD Health Care Incentive Program which will enable you to use your VISA/MASTERCARD to automatically cover amounts not paid by your insurance.

**For Our Patients Using Delta Dental Insurance:**

- We will submit your dental claim electronically on the same day of your treatment visit.
- Delta Dental will forward payment directly to you not Dr. Puglisi or our office.
- It may take up to 3 weeks for reimbursement, so please contact us as soon as you have received payment from Delta Dental.
- We will automatically charge your credit card for your treatment after 30 days if you have not notified us.