New Patient Information

First Name: ____________________ Middle Initial ________ Last Name: ________________________________

Address: ____ City/State/Zip: _________________________________

Home Phone: _____________________ Work: ___________________________ Cell Phone: _____________________

Birth Date: _____/_____/_____ Social Security #: _________-_________-_________

Sex: Male/Female Marital Status: M S D W

Email: ____

Patient's Employer: ____

Spouse: ____

Spouse Date of Birth: _____/_____/_____ Social Security #: ________-_______-________

Spouse's Employer: ____

Responsible Party

Person Responsible for Account: ____

Address: ____

Home Phone: _________________________ Work: __________________________ Cell Phone: _____________________

Birth Date: _____/_____/_____ Social Security #: _________-_________-_________

Primary Dental Insurance

Name of Insured: ___________________________________ Patient Relationship: ______________________________

Address: ____ City/Sate: _____________________________

Birth Date: _____/_____/_____ Social Security #: _________-_________-_________ Phone:
____

Insurance Company: ____

Employer: ____

Emergency Contact:

Name: ____ Phone: ____

Name: ____ Phone: ____

Name: ____ Phone: ____

RONALD A. TOSTO, DDS

FINACIAL AGREEMENT

As our patient, we want to provide you the best care possible. There may be certain routine services that we feel are necessary for the maintenance of good oral health which are not covered by insurance. You will be responsible to pay for all services not covered. **Co-Payment/Deductibles are due at the time of service.** I have read the policy and, by my signature, agree to pay for services not covered by my insurance as well as any legal and/or collection fees necessary for the collection of this debt.

ACKNOWLEDGE OR RECEIPT:

I acknowledge that I have received and/or read a copy of Dr. Ronald A. Tosto, DDS. Notice of Privacy Practices.

ASSIGNMENT AND RELEASE:

I assign to Dr. Ronald A. Tosto, DDS, benefits, if any, otherwise payable to me for services(s) rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

The signature below is acknowledgement of HIPPA Consent, Notice of Privacy Policies, Insurance Authorization and Release and Financial Policies of this office.

Patient Signature: ______________________________________ Date: ________________

RONALD A. TOSTO, DDS

Patient Name:___________________________ **Date of Birth:** ______________ **Today's Date:** ______________

Social Security #: ____________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may, or medication that you make be taking.

Who is your Primary Care Physician?

Last Date seen:

Have you ever been hospitalized or had any major operation? Yes/No

If Yes:

Have you ever a serious head injury? Yes/No

If Yes:

Are you taking any medications, pills or drugs? (If you have a list, we can scan it for you).
Yes/No

If Yes:

Do you take, or have you taken, Phen-Fen or Reudx? Yes/No

If Yes:

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Yes/No

If Yes:

Do you use controlled substances? Yes/No

If Yes:

Have you been diagnosed with Cancer? Yes/No

Are you currently being treated with Chemotherapy? Yes/No

If so, do you know your white blood cell count? ______________________

Are you on a special diet? Yes/No

Do you use tobacco? Yes/No

WOMEN: Are you…

Pregnant? Yes/No **Nursing?** Yes/No **Taking oral contraceptives?** Yes/No

Are you allergic to any of the following?

Aspirin	Yes/No	Penicillin	Yes/No	Codeine	Yes/No	Acrylic	Yes/No
Metal	Yes/No	Latex	Yes/No	Sulfa Drugs	Yes/No	Local Anesthetics	Yes/No

Other: ____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes/No	Cortisone Medicine	Yes/No	Thyroid Disease	Yes/No
Alzheimer's Disease	Yes/No	Diabetes	Yes/No	Tonsillitis	Yes/No
Anaphylaxis	Yes/No	Drug Addiction	Yes/No	Tuberculosis	Yes/No
Anemia	Yes/No	Easily Winded	Yes/No	Tumors or Growths	Yes/No
Angina	Yes/No	Emphysema	Yes/No	Ulcers	Yes/No
Arthritis/Gout	Yes/No	Epilepsy or Seizures	Yes/No	Venereal Disease	Yes/No
Artificial Heart Valve	Yes/No	Excessive Bleeding	Yes/No	Yellow Jaundice	Yes/No
Artificial Joint	Yes/No	Excessive Thirst	Yes/No	Low Blood Pressure	Yes/No
Asthma	Yes/No	Fainting Spells/Dizziness	Yes/No	Swelling of Limbs	Yes/No
Blood Disease	Yes/No	Frequent Cough	Yes/No	Liver Disease	Yes/No
Blood Transfusion	Yes/No	Frequent Diarrhea	Yes/No	Stroke	Yes/No
Breathing Problems	Yes/No	Frequent Headaches	Yes/No	Leukemia	Yes/No
Bruise Easily	Yes/No	Genital Herpes	Yes/No	Kidney Problems	Yes/No
Cancer	Yes/No	Glaucoma	Yes/No	Spina Bifida	Yes/No
Chemotherapy	Yes/No	Hay Fever	Yes/No	Irregular Heartbeat	Yes/No

Chest Pains	Yes/No	Heart Attack/Failure	Yes/No	Sinus Trouble	Yes/No
Cold Sores/Fever Blisters	Yes/No	Heart Murmur	Yes/No	Hypoglycemia	Yes/No
Congenital Heart Disorder	Yes/No	Heart Pacemaker	Yes/No	Sickle Cell Disease	Yes/No
Convulsions	Yes/No	Heart Trouble/Disease	Yes/No	Hives/Rash	Yes/No
Hemophilia	Yes/No	Radiation Treatments	Yes/No	Shingles	Yes/No
Hepatitis A, B, C	Yes/No	Recent weight loss	Yes/No	High Cholesterol	Yes/No
Herpes	Yes/No	Renal Dialysis	Yes/No	Scarlet Fever	Yes/No
High Blood Pressure	Yes/No	Rheumatism	Yes/No	Stomach/Intestinal Disease	Yes/No

Have you ever had, and serious illness not listed above? Yes/No

Comments:

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Patients Signature: ______________________________________ **Today's Date:** ____________________

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare provider who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and discloser of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken the necessary action with relying on this consent.

Patient Name: ______________________________ Date: __________________________

Patient Signature: ____

Relationship to Patient (If under 18): ____

Email Address: ____