Anthony Scianni DMD

General, Cosmetic & Implant Dentistry

Welcome to Our Office - Tell Us About Yourself

Name: ____
Last First MI Title

Address:_______________________________ City:________________ State:_____ Zip:__________

SSN:_______________________ ❑ Male ❑ Female DOB:_________________

Home Phone:____________________________ Work Phone: ___________________________

Cell Phone: ___________________ E-Mail:____

Employer: ___________________________ Occupation: _____________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

How did you hear about our office? ____

Do you prefer to be contacted for appointment confirmation via ❑ E-mail ❑ Text ❑ Phone

Insurance- Primary

Subscriber Name:________________________ Relationship to Patient:________ Subscriber DOB: __________

Subscriber SSN/ID: ___________________ Subscriber Employer:_____________________________

Insurance Company Name: __________________Phone #_______________Group # ______________

Insurance Company Address: ____

Insurance- Secondary

Subscriber Name:________________________ Relationship to Patient:________ Subscriber DOB: __________

Subscriber SSN/ID: ___________________ Subscriber Employer:_____________________________

Insurance Company Name: __________________Phone #_______________Group# ______________

Insurance Company Address: ____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assigned directly to Anthony Scianni, DMD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Dr. to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____

Relationship: _________________________________ Date: ___________________________

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/ Guardian Signature: ____

Anthony Scianni DMD

Medical History

Do you have personal physician? ❑ Yes ❑ No

Physician's Name:________________ ___________________ Phone #_____________________Date of last visit_____________

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain:____

Do you use tobacco in any form? ❑ Yes ❑ No

Have you had any metal rods, pins, implants placed, or any artificial joints (hip, knee, etc.)? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑ No

Please list each one:____

Have you ever had any surgical procedures? ❑ Yes ❑ No

Please list each one:____

Yes	No	Conditions
❑	❑	Abnormal Bleeding
❑	❑	Alcohol Abuse
❑	❑	Allergies or Hives
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Heart Valve
❑	❑	Asthma
❑	❑	Blood Transfusion
❑	❑	Cancer
❑	❑	Chemotherapy
❑	❑	Chest Pains
❑	❑	Chronic Cough
❑	❑	Colitis
❑	❑	Congenital Heart Defect
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Facial Surgery
❑	❑	Fainting Spells
❑	❑	Fever Blisters
❑	❑	Frequent Headaches

Yes	No	Conditions
❑	❑	Glaucoma
❑	❑	HIV+ AIDS
❑	❑	Heart Attack
❑	❑	Heart Murmur
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	Hepatitis C
❑	❑	High Blood Pressure
❑	❑	Joint Replacement
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Neurological Disorders
❑	❑	Pace Maker
❑	❑	Psychological Problems
❑	❑	Radiation Therapy
❑	❑	Rheumatic Fever
❑	❑	Seizures
❑	❑	Sexually Transmitted Disease
❑	❑	Shingles
❑	❑	Sickle Cell Disease

Yes	No	Conditions
❑	❑	Sinus Problems
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Tuberculosis
❑	❑	Ulcers
❑	❑	Other__________________________

Yes	No	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Jewelry
❑	❑	Latex
❑	❑	Metals
❑	❑	Penicillin
❑	❑	Tetracycline
❑	❑	Other___________________________

Yes	No	If Female, Please Answer
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If so, # of weeks ___
❑	❑	Are you nursing?

Nearest relative not living with you:

Name:____Relationship:___________________

Address:____ Phone:________________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this infor-mation will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:____Date:______________________

Anthony Scianni DMD

Dental History

How may we help you today? ____________________

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatments? ❑ Yes ❑ No

Do you now or have you had any pain/ discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No

Are you under stress? (New job, moving, relationships) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Is there anything you'd like to change about your smile? ❑ Yes ❑ No If Yes, What: ____________________

Are you happy with the color of your teeth? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

How many times do you: floss/week? ____________________ brush/day?____________________

Are your teeth sensitive to hot, cold or anything else? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning? ____________________

When was your last dental visit? ____________________

Why did you leave your previous dentist? ____________________

How can we accommodate you better during your dental visit? ____________________

We offer a wide variety of services to enhance and keep your smile youthful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Deep bleaching	Veneers / Lumineers	Invisalign	Cosmetic Dental Imaging
Smile makeover	Bonding	Crown and Bridge	Denture Stabilization for Loose Dentures
Implants	Night guards	Athletic Mouthguards	Canker Sore Treatment
Dentures	Tooth Colored Fillings	Snap On Smile	Cold Sore Treatment

Anthony Scianni DMD

Consent for Treatment

I understand the above information is necessary provide to me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

I hereby authorize Dr. Scianni or designated staff to take x-rays, study models, photos and other diagnostic aids deemed appropriate by Dr. Scianni to make a thorough diagnosis of the dental needs of:

(patient name)____.

Upon such diagnosis, I authorize Dr. Scianni to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper dental care. I agree to the use of dental anesthetics, sedatives and other medication as necessary. I fully understand that using these drugs and dental treatment embody certain risks (adverse reaction, nerve or muscular damage, bleeding, infection, etc.). I understand that the results/outcome of dental treatment is influenced by factors outside of Dr. Scianni's control and that more extensive treatment could ultimately be required. I give consent to Dr. Scianni or designated staff to use and disclose any oral, and written, or electronic health records that are individually identifiable as mine the purpose of carrying out my treatment, payment and health care operations. I understand that a notice fully outlining the protection of my personal health information is available.

I understand the responsibility for payment for dental services provided in this office for myself or my dependence is mine, due and payable at the time services are rendered of less financial arrangements have been made in advance. I further understand that a 1 1/2% finance charge per month (18% annually) will be added to any balance over 60 days. In the event of default I (we) promised to pay legal interest on the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collection of this note.

Patient/Guardian Signature:_______ ____

Relationship to Patient:____ Date:______________________________________

Insurance and Financial Policy

We believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Initial
_______ ■ Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

_______ ■ We currently **accept** all private care insurance plans (plans that do not require you to select a dentist from a list). This means that we work with literally thousands of companies. We also **participate** with a select few insurance companies in which we have a contract to provide you with dental services (please contact our office to determine if we participate with your insurance company). Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

_______ ■ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_______ ■ We require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, cash, and checks for existing patients. If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6, 12 or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

_______ ■ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 24 hour** notice to avoid a **$50/hour cancellation fee** (emergencies are an exception).

_______ ■ In the event of an emergency after regular business hours a **$55 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **$125 after hours emergency fee.**

I agree with the above conditions.

Print Name:_______________________________________ Date: ___________________

Patient/Parent Signature: ____