Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

PATIENT INFORMATION

DATE:_____ SS#:_____

BIRTHDATE:_____

NAME:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

____ MALE ____ FEMALE

____MARRIED ____WIDOW ____SINGLE ____MINOR

____ SEPARATED ____DIVORCED ____PARTNERED ____ YRS

PATIENT EMPLOYER/SCHOOL: _____

EMPLOYER/SCHOOL ADDRESS:_____

_____

SPOUSE'S NAME:_____

BIRTHDATE:_____

EMPLOYER:_____

ADDRESS:_____

PHONE NUMBERS

HOME: (____) _____

WORK: (____) _____

CELL: (____) _____

EMAIL: _____

SPOUSE'S WORK (____)_____

BEST TIME AND PLACE TO REACH YOU:

_____

INCASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

NAME:

_____

RELATIONSHIP: _____

HOME PHONE: (____) _____

WORK PHONE: (____) _____

WHOM MAY WE THANK FOR REFERRING YOU?

___ Existing Patient Name:_____

___GOOGLE ___FACEBOOK/INSTAGRAM ____SIGN ____BROCHURE/NEWSLETTER ___WALK-IN

DENTAL HISTORY

REASON FOR TODAYS VISIT_____
DATE OF LAST DENTAL VISIT_____
DATE OF LAST DENTAL X-RAYS_____

FORMER DENTIST_____
CITY/STATE_____

HAVE YOU HAD ANY OF THE FOLLOWING:

Bad breath	___YES ___NO	Burning sensation on tongue	___YES ___NO	Mouth Breathing	___YES ___NO
Bleeding gums	___YES ___NO	Chew on one side of mouth	___YES ___NO	Mouth pain, brushing	___YES ___NO
Blisters on lips or mouth	___YES ___NO	Cigarette, pipe or cigar smoking	___YES ___NO	Orthodontic treatment	___YES ___NO
		Clicking or popping jaw	___YES ___NO	Pain around ear	___YES ___NO
		Dry mouth	___YES ___NO	Periodontal treatment	___YES ___NO
		Fingernail biting	___YES ___NO	Sensitivity to cold	___YES ___NO
		Food collection between teeth	___YES ___NO	Sensitivity to heat	___YES ___NO
		Foreign objects	___YES ___NO	Sensitivity to sweets	___YES ___NO
		Grinding teeth	___YES ___NO	Sensitivity when biting	___YES ___NO
		Gums swollen or tender	___YES ___NO	Sores or growths in your mouth	___YES ___NO
		Jaw pain or tiredness	___YES ___NO	How often do you floss_____	
		Lip or cheek biting	___YES ___NO	How often do you brush?_____	
		Loose teeth or broken fillings	___YES ___NO		

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN'S NAME: _____ DATE OF LAST VISIT: _____

HAVE YOU EVER TAKEN ANY OF THE GROUP OF DRUGS COLLECTIVELY REFERRED TO AS "FEN-PHEN"? These include combinations of Ionimin, Adipez, Fastin (brand maes of phentermine), Pondimin (fenfluramine) and Reduz (dexafenfluramine) ___YES ___NO

Have you ever had any serious illnesses or operations? ___YES ___NO If yes, describe _____

Have you ever had a blood transfusion? ___YES ___NO If yes, describe _____

(Women) Are you pregnant? ___YES ___NO Nursing? ___YES ___NO Taking birth control pills? ___YES ___NO

PREFERRED PHARMACY: _____ **TELE#:** _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Anemia	___YES ___NO	Fainting	___YES ___NO	Radiation Treatment	___YES ___NO
Arthritis, Rheumatism	___YES ___NO	Glaucoma	___YES ___NO	Respiratory Disease	___YES ___NO
Artificial Heart Valves	___YES ___NO	Headaches	___YES ___NO	Rheumatic Fever	___YES ___NO
Artificial Joints, Pins, etc.	___YES ___NO	Heart Murmur	___YES ___NO	Scarlet Fever	___YES ___NO
Asthma	___YES ___NO	Heart Problems	___YES ___NO	Shortness of Breath	___YES ___NO
Back Problems	___YES ___NO	Hemophilia	___YES ___NO	Skin Rash	___YES ___NO
Bleeding Abnormally	___YES ___NO	Hepatitis	___YES ___NO	Stroke	___YES ___NO
Blood Disease	___YES ___NO	Hernia Repair	___YES ___NO	Swelling of feet and ankles	___YES ___NO
Cancer	___YES ___NO	High Blood Pressure	___YES ___NO	Thyroid Disease	___YES ___NO
Chemotherapy	___YES ___NO	HIV/AIDS	___YES ___NO	Tobacco Habit	___YES ___NO
Circulatory Problems	___YES ___NO	Kidney Disease	___YES ___NO	Tonsillitis	___YES ___NO
Congenital Heart Lesions	___YES ___NO	Liver Disease	___YES ___NO	Tuberculosis	___YES ___NO
Diabetes	___YES ___NO	Mitral Valve Prolapse	___YES ___NO	Ulcer	___YES ___NO
Epilepsy	___YES ___NO	Pacemaker	___YES ___NO	Venereal Disease	___YES ___NO

List any medications you are currently taking and the correlating diagnosis:

_____
_____
_____
_____

Allergies:

_____
_____
_____
_____

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Date

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____
Date

Financial Agreement

I understand:

- I am responsible to pay all estimated charges at the time services are rendered unless other arrangements have been made prior.
- It is my responsibility to notify Rauzman Dental of any dental insurance changes prior to any appointment.
- Rauzman Dental is only able to estimate what my insurance may cover based on the information given by my insurance company.
- My contract is with my insurance company and not with Rauzman Dental unless I am covered under the In-House Dental Savings Plan. (For more information, see the front desk)
- It is my responsibility to know the terms and limitations of my policy, including deductibles, co-pays, maximums, maximum renewal dates and coordination of benefit details.
- Any estimates by my insurance company are **only** estimates and **not** guarantee of payment.
- It is my responsibility to pay any balances unpaid by my insurance company.
- I will assume all costs associated with collection of my account.
- Late fees may apply if my account falls 30 days past due unless other arrangements have been made prior.
- If a payment plan has been made, 2 missed payments will void my arrangement and my balance will be due in full.
- I have authorized Rauzman Dental to release my information for the payment of dental claims and assign payment to their office.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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RAUZMAN DENTAL
GENERAL, COSMETIC & BRILLIANT DENTISTRY

To Our Patients,

We have found it necessary to institute a policy in regard to last minute cancelations and missed appointments. We do not double book our schedule so that we may give our patients the time and attention they deserve. Consequently, if patients do not show up for their appointments, we have an empty time slot in which another patient could have been seen.

We therefore request notification by phone, 48 hours prior to your appointment, if you cannot keep it. If we do not receive notification, and you do not show for your appointment, there will be a fee charged of $50, for which you will be responsible.

Thank you in advance for your courtesy regarding your appointments.

Sincerely,

Dr. Adam Rauzman

Please sign here to confirm your understanding of the policy:

_____ _____

SIGNATURE of PATIENT or GUARDIAN DATE

_____

PRINT

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PATIENT HIPAA AWARENESS

With my permission, Drs. Pallotta & Rauzman may use and disclose protected health information (**PHI**) about me to carry out treatment, payment and healthcare operations (**TPO**). Please refer to the office :Notice of Privacy Practices: for a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Drs. Pallotta & Rauzman reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Drs. Pallotta & Rauzman may call home or other designated locations and leave a message on voice mail or in person about any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Drs. Pallotta & Rauzman may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal or Confidential.

With my permission, the office of Drs. Pallotta & Rauzman may email to my home or other such designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Drs. Pallotta & Rauzman restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing I am allowing Drs. Pallotta & Rauzman to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent.

_____ _____

SIGNATURE of PATIENT or GUARDIAN DATE

_____

PRINT

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