Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name ______________________________ Soc. Sec. # ______________
Last Name First Name Middle Initial

Address ______________________________ Home Phone ______________

City ______________ State ______ Zip ______ Email ______________

Sex ☐ M ☐ F Age ______ Birthdate ______________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by ______________________________ Occupation ______________

Business Address ______________________________ Business Phone ______________

Whom may we thank for referring you? ______________________________

Notify in case of emergency ______________ Home Phone ______________ Work Phone ______________

Cell Phone ______________ Business Email ______________

Primary Insurance

DL: ______________________________

Person Responsible for Account ______________________________
Last Name First Name Middle Initial

Relation to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address (if different from patient) ______________________________ Home Phone ______________

City ______________________________ State ______ Zip ______

Cell Phone ______________________________ Email ______________

Person Responsible Employed by ______________________________ Occupation ______________

Business Address ______________________________ Business Phone ______________

Business Email ______________________________

Insurance Company ______________________________ Phone ______________

Contract # ______________ Group # ______________ Subscriber's # ______________

Name(s) of other dependents under this plan ______________________________

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________ Relation to Patient ______________ Birthdate ______________

Address (if different from patient) ______________________________ Soc. Sec. # ______________

City ______________ State ______ Zip ______ Home Phone ______________

Cell Phone ______________________________ Business Phone ______________

Subscriber Employed by ______________________________ Business Email ______________

Insurance Company ______________ Phone ______________ Insurance Email ______________

Contract # ______________ Group # ______________ Subscriber's # ______________

Name(s) of other dependents under this plan ______________________________

Please complete both sides.

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What would you like us to do today? ____________________

Are you in dental discomfort today? ____________________

Former Dentist ____________________ Address ____________________ Phone ____________

Dentist's Email ____________________

Date of last dental care ____________________ Date of last X-rays ____________________

Check Y for yes or N for no if you have or have not had the following:

☐ Y ☐ N Bad breath	☐ Y ☐ N Food collection between teeth	☐ Y ☐ N Periodontal treatment	☐ Y ☐ N Sensitivity to sweets
☐ Y ☐ N Bleeding gums	☐ Y ☐ N Grinding or clenching teeth	☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity when biting
☐ Y ☐ N Clicking or popping jaw	☐ Y ☐ N Loose teeth or broken fillings	☐ Y ☐ N Sensitivity to hot	☐ Y ☐ N Sores or growths in mouth

How often do you brush? ____________________ How often do you floss? ____________

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

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Medical History

Physician's name ____________________ Address ____________________ Phone ____________

Physician's Email ____________________

Date of last visit __________ Have you had any serious illnesses or operations? ☐ Y ☐ N If yes, describe ____________

Are you currently under physician care? ☐ Y ☐ N If yes, describe ____________________

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates ____________________

Have you ever taken Fen-Phen/Redux? ☐ Y ☐ N

Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check **Y** for yés or **N** for no if you have had any of the following:

- ☐ Y ☐ N AIDS/HIV Positive
- ☐ Y ☐ N Anaphylaxis
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Arthritis, Rheumatism
- ☐ Y ☐ N Artificial heart valves
- ☐ Y ☐ N Artificial joints
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Atopic (allergy prone)
- ☐ Y ☐ N Back problems
- ☐ Y ☐ N Blood disease
- ☐ Y ☐ N Cancer
- ☐ Y ☐ N Chemical dependency
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Circulatory problems
- ☐ Y ☐ N Cortisone treatments
- ☐ Y ☐ N Cough, persistent
- ☐ Y ☐ N Cough up blood
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting
- ☐ Y ☐ N Food allergies
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Headaches
- ☐ Y ☐ N Heart murmur
- ☐ Y ☐ N Heart problems
  Describe ____________
- ☐ Y ☐ N Hemophilia/Abnormal bleeding
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N High blood pressure
- ☐ Y ☐ N Jaw pain
- ☐ Y ☐ N Kidney disease or malfunction
- ☐ Y ☐ N Liver disease
- ☐ Y ☐ N Material allergies
  (latex, wool, metal, chemicals)
- ☐ Y ☐ N Mitral valve prolapse
- ☐ Y ☐ N Nervous problems
- ☐ Y ☐ N Pacemaker/Heart surgery
- ☐ Y ☐ N Psychiatric care
- ☐ Y ☐ N Rapid weight gain or loss
- ☐ Y ☐ N Radiation treatment
- ☐ Y ☐ N Respiratory disease
- ☐ Y ☐ N Rheumatic fever
- ☐ Y ☐ N Scarlet fever
- ☐ Y ☐ N Shingles
- ☐ Y ☐ N Shortness of breath
- ☐ Y ☐ N Skin rash
- ☐ Y ☐ N Spina Bifida
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Surgical implant
- ☐ Y ☐ N Swelling of feet or ankles
- ☐ Y ☐ N Thyroid disease or malfunction
- ☐ Y ☐ N Tobacco habit
- ☐ Y ☐ N Tonsillitis
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Ulcer/Colitis
- ☐ Y ☐ N Venereal disease

List medications you are currently taking, if any:

____

____

List drug allergies, if any: ____________________

____

____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____________________ Date ____________

Payment is due in full at time of treatment unless prior arrangements have been approved.

FEDERICI DENTAL, P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name. ______________________ Date of Birth: __________ SS# ______________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting.

Contact Person: Telephone: 609-597-1234; Address: 1301 Rte 72 W. Unit 230 Manahawkin, NJ 08050

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ______________________ Date: ______________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name ______________________

Relationship to Patient. ______________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent

Signature: ______________________ Date ______________

Medical Information Release Form
(HIPAA Release Form)

Name: ______________________________ Date of Birth: ___/___/_____

Release of Information

[] I authorize the release of information including the diagnosis, records; Examination rendered to me and claims information. This information may be released to:

[] Spouse ____________________________ - Phone ____________________

[] Children ____________________________ - Phone ____________________

[] Other ____________________________ - Phone ____________________

[] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [] my home [] my work [] my cell number: __________________
If unable to reach me:

[] you may leave a detailed message
[] please leave a message asking me to return your call
[] ____

The best time to reach me is (day) __________________ between (time) ____________

Signed: ____________________________________ Date ___/___/_____

Witness: ____________________________________ Date ___/___/_____

JOSEPH R. FEDERICI, DMD

DAVID E. FEDERICI, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, X________________________________, have received a copy of this office's Notice of Privacy Practices.

X________________________________
{Please Print Name}

X________________________________
{Signature}

X________________________________
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but 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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FEDERICI DENTAL

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SLEEP HISTORY QUESTIONNAIRE

Present Findings:
[ ] You are sleepy
[ ] You are tired
[ ] You snore
[ ] You have trouble falling asleep
[ ] You waken often at night
[ ] You have trouble falling back to sleep
[ ] You nap
[ ] The head of your bed is raised
[ ] Read or watch television in bed before sleep
[ ] You waken refreshed
[ ] You waken as tired as the night before
[ ] You prefer to sleep on your stomach
[ ] You prefer to sleep on your back
[ ] You prefer to sleep on your side
[ ] You have a regular bed time
[ ] You sleep less than 6 hours each night
[ ] You sleep more than 10 hours each night
[ ] You use the bathroom more than once per night
[ ] You lack energy
[ ] You work rotating shifts
[ ] You travel frequently
[ ] You often have an alcoholic nightcap

Sleep Style:
[ ] Bedtime is before midnight
[ ] Bedtime is after midnight
[ ] You sleep alone
[ ] You sleep with an adult bed partner
[ ] You sleep with pets
[ ] You sleep with children in the bed
[ ] You need a bedroom that is quiet and dark
[ ] Your partner's sleep habits disrupt you
[ ] Nothing disturbs your sleep
[ ] You are an active sleeper
[ ] You frequently drink water at night

In The Past Five Years Have You Had:
[ ] Nightmares
[ ] Sleepwalking
[ ] Sleep talking
[ ] Headaches upon wakening
[ ] Leg discomfort at night
[ ] Leg discomfort that eases with movement
[ ] Panic attacks at night
[ ] Acid reflux at night only
[ ] Better sleep in a recliner

Sleep Treatments:
[ ] CPAP
[ ] Nasal surgery
[ ] Throat surgery
[ ] Oral appliance for snoring
[ ] Stay off back at night
[ ] Nasal strips, nasal dilators
[ ] Medications to aid sleep onset
[ ] Other: ______________________________

Family Sleep History:
[ ] Father snores or has symptoms of sleep apnea
[ ] Siblings snore or have symptoms of sleep apnea
[ ] Children snore or have symptoms of sleep apnea
[ ] Other relatives snore or may have sleep apnea

Other:
[ ] You wear dentures when you sleep
[ ] You wear a night guard when you sleep
[ ] You wear bleaching trays at night

Patient Signature: ______________________________

Patient Print Name: ______________________________

Date: ______________________________