PATIENT REGISTRATION

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Patient Is: ☐ Policy Holder ☐ Responsible Party

Address: _____ Address 2: _____

City, State, Zip: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Sex: ☐ Male ☐ Female

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Email: _____

Would you like to be contacted via email? ☐Yes ☐No

Would you like us to provide you with appointment reminders? ☐Yes ☐No

If yes, which method(s) do you prefer: ☐ Home ☐ Work ☐ Cell ☐ Email

Emergency Contact:

Name: _____

Relation to Patient: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Responsible Party (if someone other than the patient) – responsible for financial obligations

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____ Age: _____

☐ Responsible Party is also the Policy Holder for Patient

Primary Insurance/Policy Holder Information

Name of Policy Holder: _____ Contact Number: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Soc. Security Number: _____ Birth Date: _____

Subscriber ID: _____

Employer: _____ Ins. Company: _____

Phone Number: _____ Phone Number: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Time 9:32 AM

Date 6/24/2015

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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 have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Yellow Jaundice	○ Yes ○ No						

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

WALTER M.
MAZZELLA, D.D.S.
FAMILY & COSMETIC DENTISTRY

Waverly Woods Village Center
10775 Birmingham Way, Ste.1
Woodstock, MD 21163

Phone: 410-203-2552
Fax:410-203-2546
Website: www.mazzelladental.com

Dental History Form

How did you hear about this dental office?

When was your last dental check-up?

When was the last time you had dental x-rays?

When was the last time you had any dental work done, i.e. fillings, crowns, etc.?

Are any of your teeth chipped or cracked?

Do you get food caught between your teeth?

Do you have any issues with your gums?

Do your gums bleed when you brush your teeth?

Is there anything you would like to change about the appearance of your teeth?

Do you snore? If so, is your snoring a problem in your household?

Overall, how would you rate the health of your mouth?

Comments:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
MAZZELLA FAMILY AND COSMETIC DENTISRY

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

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

I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that Mazzella Family and Cosmetic Dentistry has the right to change its Notice of Privacy Practices from time to time and that I may contact Mazzella Family and Cosmetic Dentistry at any time 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 and health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient(s) Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

IF ANY MEDICAL OR INSURANCE PROVIDERS SHOULD NOT HAVE ACCESS TO THE PATIENT'S MEDICAL OR FINANCIAL INFORMATION, PLEASE STATE THEIR NAME(S) HERE:

Name: _____ Date: _____

Name: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

Dental Office Policies

Appointment Cancellation Policy

Your scheduled appointment time has been reserved specifically for you. We are aware that unforeseen events sometimes require missing an appointment, however we request **24 hours notice** if you need to cancel your appointment. A **$50.00/hour Missed Appointment Fee** will be added to your account after missing your second appointment without notifying us 24 hours in advance.

Late Arrival Policy

We respect our patients' time and make every effort to remain on schedule. We expect our patients to arrive on time as well. If you are going to be late, please notify us. We reserve the right to reschedule your appointment and charge our Missed Appointment Fee if you arrive more than 10 minutes after the start of your reserved appointment time.

Fees & Payment Options

Payment is expected when services are rendered. We understand that quality dental work is not cheap, and we are willing to make arrangements before the time of your visit if you are unable to pay the whole amount upfront. To make payment more convenient for you, we accept cash, personal checks, VISA, MasterCard, Discover and CareCredit.

Dental Insurance Policies

We do our very best to give an accurate estimation of how much insurance will cover for a given procedure. However, insurance estimation is not a guarantee of payment. Actual benefits will be determined when the services are completed and submitted for payment. Please keep in mind you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.

I have read and agree to the above policies.

Patient Name: _____ Date: _____

Patient or Guardian Signature: _____

WALTER M.
MAZZELLA, D.D.S.
FAMILY & COSMETIC DENTISTRY

Waverly Woods Village Center
10775 Birmingham Way, Suite 1
Woodstock, MD 21163
Phone: 410.203.2552
Fax: 410.203.2546
MazzellaDental.com

Patient Photo Release Form

I_____, hereby authorize Walter M. Mazzella, D.D. S. or any of his employees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc.).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please initial one option:

____I do not mind if my photographs are used in any of the above stated situations.

____I only agree to have my teeth shown without any identifying features.

Signed_____ Date _____

Periodontal Risk Assessment Questionnaire

Name _____ Date _____

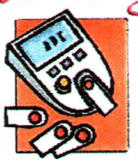
Tobacco Use

Tobacco use is the most significant risk factor for gum disease.

Do you now or have you ever used the following:

	Amounts per day	Used for how many years	If you quit, list what year
❑ Cigarette	_____	_____	_____
❑ Cigar	_____	_____	_____
❑ Pipe	_____	_____	_____
❑ Chewing	_____	_____	_____

Blood Sugar



Diabetes

Gum disease is a common complication of diabetes. Untreated gum disease makes it harder for patients with diabetes to control their blood sugar.

IF YOU ARE A PATIENT WHO HAS DIABETES:

Is your diabetes under control? ❑ Yes ❑ No

Are you prone to diabetic complications? ❑ Yes ❑ No

How do you monitor your blood sugar? _____

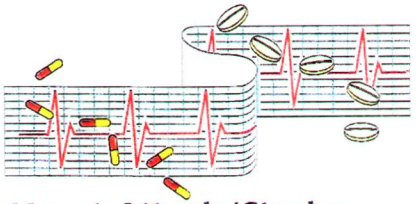
Who is your physician for diabetes? _____

IF YOU ARE NOT A PATIENT WHO HAS DIABETES:

Any family history of diabetes? ❑ Yes ❑ No

Have you had any of these warning signs of diabetes?

- ❑ frequent urination
- ❑ excessive thirst
- ❑ excessive hunger
- ❑ weakness and fatigue
- ❑ slow healing of cuts
- ❑ unexplained weight loss



Heart Attack/Stroke

Untreated gum disease may increase your risk for heart attack or stroke.

Do you have any risk factors for heart disease or stroke?

- ❑ Family history of heart disease
- ❑ Tobacco use
- ❑ Obesity
- ❑ High cholesterol
- ❑ High blood pressure

If you have any of these other risk factors it is especially important for you to always keep your gums as healthy as possible.

Medications

A side effect of some medications can cause changes in your gums.

Are you taking or have you ever taken any of the following medication:

❑ Antiseizure medications. (such as Dilantin®, Tegretol®, Phenobarbital, etc.)

❑ Yes ❑ No

If you answered yes, are you still taking the anti-seizure medication?

❑ Yes ❑ No

Other Medication: _____

❑ Calcium Channel Blocker blood pressure medication. (such as Procardia®, Cardizem®, Norvasc®, Verapamil®, etc.)

Other: _____

❑ Immunosuppressant therapy (such as Prednisone, Azathioprine, Cyclosporins, Corticosteriods (Asthma-Inhalers), etc.)

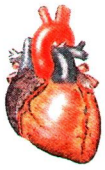
Other: _____

Family History/ Genetics

The tendency for gum disease to develop can be inherited.

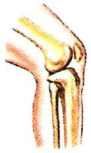
Is there an immediate family member(s) who currently has or had gum problems in the past? (e.g. your mother, father, or siblings):

❑ Yes ❑ No



Heart Murmur, Artificial joint prosthesis

If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and may cause a serious infection of the heart or joints.



Do you have a heart murmur or artificial joint?

❑ Yes ❑ No

If so, does your physician recommend antibiotics prior to dental visits?

❑ Yes ❑ No

Name of physician? _____

If you answered yes, it is especially important to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.

Females

Females can be at increased risk for gum disease at different points in their lives.

The following can adversely affect your gums. Please check all that apply:

❑ Pregnant ❑ Nursing ❑ Menopause

❑ Taking birth control pills

❑ Infrequent care during previous pregnancies

Women

Women with osteoporosis have a greater risk for periodontal bone loss.

Females:

Do you take any of the following:

❑ Estrogen Replacement Therapy/Hormone Replacement Therapy (such as Prempro®, Premarin®, Premphase®, Fosamax®, Actonel®, Evista®, Fortéo®, etc.)

Other: _____

Stress

High levels of stress can reduce your body's immune defense.

Are you under a lot of stress?

❑ Yes ❑ No

Nutrition

Your diet has the potential to affect your periodontal health.

Do you find it difficult to maintain a well-balanced diet?

❑ Yes ❑ No

All patients please complete the following:

Have you noticed any of the following signs of gum disease?

❑ Bleeding gums during toothbrushing

❑ Red, swollen or tender gums

❑ Gums that have pulled away from the teeth

❑ Persistent bad breath

❑ Pus between the teeth and gums

❑ Loose or separating teeth

❑ Change in the way your teeth fit together

❑ Food catching between teeth

Is it important to keep your teeth for as long as possible? ❑ Yes ❑ Not really

If you have missing teeth, why have you not had them replaced? _____

Do you like the appearance of your smile? ❑ Yes ❑ No

Do you like the color of your teeth? ❑ Yes ❑ No

Do your teeth keep you from eating any specific food? ❑ Yes ❑ No

PER 10371

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