

D. K. Fagundes, D.M.D., M.S., P.C.
Welcome to our office!

PATIENT INFORMATION

PLEASE PROVIDE TWO FORMS of I.D. & DENTAL INSURANCE CARDS TO FRONT DESK.

Can we thank a friend or relative for referring you to our office? Name _____

*Please rate your pain at this time 0-10, (10 worst) 0 1 2 3 4 5 6 7 8 9 10

Patient Name: _____ General Dentist: _____
(If P.O. Box, please give street address also)

Address: _____

City: _____ State: _____ Zip: _____ E-Mail: _____

Home Phone: _____ Work: _____ Cell: _____

SSN: _____ Date of Birth: _____

Employer: _____ Address: _____

Marital Status: _____ Spouse: _____ Phone: _____

Spouse's Employer/Address: _____ Emp. Phone: _____

EMERGENCY Contact: _____ Phone: _____ Rel to pt: _____

RESPONSIBLE PARTY INFORMATION: (if other than the patient)

NAME: _____ Social: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Place of Employment _____

***** Relationship to patient _____

PRIMARY DENTAL INSURANCE COMPANY: _____

Policy Holder's Name: _____ Birthdate: _____ SSN: _____

Employer: _____ Relationship to Patient: _____

Group # : _____ Individual I D # : _____ Ins. Phone # : _____

Ins. Address: _____ City: _____ State: _____ Zip: _____

SECONDARY DENTAL INSURANCE COMPANY: _____

Policy Holder's Name: _____ Birthdate: _____ SSN: _____

Employer: _____ Relationship to Patient: _____

Group # : _____ Individual I D # : _____ Ins. Phone # : _____

Ins. Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize release of any information regarding my own or my dependant's dental claims and I authorize payment of my insurance benefits directly to D. K. Fagundes, D.M.D., M.S., P.C. for any claims submitted for work performed by Dr. Fagundes for me or my dependants.

Signed: X _____ Date: _____

D. K. Fagundes, D.M.D., M.S., P.C.

OFFICE PAYMENT POLICY

Payment is expected at the time of service for any amounts not expected to be covered by your insurance. We will file DENTAL insurance claims as a courtesy to you. The amount we collect as a co-pay is an **ESTIMATE**. You are responsible for any balance due after your insurance has paid. The patient, not the insurance company, is responsible for the payment of fees for our services.

I will pay today by: cash ___ check ___ Debit/Credit Card ___ Care Credit _____ Other _____

I have read and understand the payment policy. I understand that the responsibility for payment for dental services provided in this office for myself or my dependents is mine. I agree to pay all collection agency fees,(33,33%), attorney fees and/or court costs associated with the process of collecting a delinquent account. Any account over 30 days past due will be assessed a monthly billing charge equal to 1 ½% of the unpaid balance (18% annually).

You agree, in order for us to service your account or to collect monies you may owe, D K Fagundes, DMD, MS,PC, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

SignatureX _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I, _____, have received a copy of this office's Notice of Privacy Practices.
(please print name)

Patient's Signature:X _____ **Date:** _____

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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) _____

D. K. Fagundes, D.M.D., M.S., P.C.
Patient Medical History

1. Has there been any change in your general health within the past year? Yes ___ No ___
Please specify _____

2. Are you under the care of a physician for a current problem? Yes ___ No ___
Nature of treatment _____
Physician's Name/Phone _____

3. Have you been hospitalized within the past five years? Yes ___ No ___
Reason _____

4. Are you taking any medications or drugs? Yes ___ No ___
Please list: _____

5. Do you take aspirin? Yes ___ No ___
Reason: _____

6. Have you received therapy for alcoholism or drug addiction during the past five years? Yes ___ No ___

7. Have you ever had any **ALLERGY OR ADVERSE REACTIONS** to anesthetics, antibiotics, or other medications? (if yes, please mark on reverse side of this form) Yes ___ No ___

8. Have you had abnormal bleeding with previous extractions, surgery, or trauma? . Yes ___ No ___

9. Have you ever required a blood transfusion? If so, please explain: _____ Yes ___ No ___
_____ Year: _____

10. Have you ever had surgery and /or radiation? Yes ___ No ___ When/Why: _____

11. Date of your last physical exam: _____

12. Do you use tobacco products? ___ How long? _____ How much per day? _____

13. Have you ever taken any of the following drugs: **Fen-Phen** (Fenfluramine & Phentermine), **Aredia**, **Zometa** or **Fosamax**? _____ If so, when and for how long? _____

14. Do you have a heart condition (mitral valve prolapse, etc.), an artificial joint or other condition *that requires you to pre-medicate* with antibiotics prior to dental treatment? Yes ___ No ___

Reason: _____

Women:

15. Are you, or do you think you may be, pregnant? Yes ___ No ___

16. Are you nursing? Yes ___ No ___

17. Do you take birth control pills? Yes ___ No ___

IF YES, be advised that if you take antibiotics, an alternate method of birth control must be used.

