RODERICK LUCENTE, DMD, PC
GENERAL DENTIST

Today's Date:__________________

Patient Information (confidential)

Patient Name____ Sex [ ] Male [ ] Female
Last First Middle

Social Security Number ____________________ Occupation/Employer________________________

Cell Phone _______________Work Phone _________________Email ________________________

Date of Birth: ________________Whom may we thank for referring you? _____________________

Address____ Apt#___________________

City_____________________ State___________ Zip_____________________________________

Emergency contact name__________________________________Phone______________________

Insurance Information

What is the patient's relationship to the insured party? [ ] Self [ ] Spouse [ ] Child [ ] Other________

Name of insured party _____________________Address ___________________________________

Insured's Social Security______________________ Insured's date of birth ______________________

Insured's Employer__________________________ Business Phone ___________________________

Insurance Company__________________________ Group #________________________________

Insurance ID # ____

If you have more than one insurance policy, please complete the next section.

What is the patient's relationship to the insured party? [ ] Self [ ] Spouse [ ] Child [ ] Other_________

Name of insured party _____________________Address ___________________________________

Insured's Social Security______________________ Insured's date of birth ______________________

Insured's Employer__________________________ Business Phone ___________________________

Insurance Company__________________________ Group #________________________________

Insurance ID # ____

RODERICK LUCENTE, DMD, PC
GENERAL DENTIST

Today's Date:____________________

Dental Health History (confidential)

Reason for today's visit____

Date of last dental exam____________________________ Date of last x-rays___________________________

Put a check in the box if you have had problems with any of the following:

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

How often do you floss?____________________How often do you brush? ____________________________

Medical History

Physician's Name____________________________________ Date of last visit________________________________

Have you had any serious illnesses or operations? ___________If yes, describe_________________________

WOMEN: Is there a possibility that you are pregnant? Yes No
Are you nursing? Yes No
Are you taking birth control pills? Yes No

Please check the box if you have or have had any of the following:

AIDS/HIV positive	Cortisone treatments	Hepatitis
Anemia	High Blood Pressure	Arthritis
Artificial Heart valves	Diabetes	Ulcer
Artificial joints	Epilepsy	Kidney disease
Stroke	Asthma	Fainting
Liver Disease	Hemophilia	Blood Disease
Headaches	Nervous Problems	Cancer
Pacemaker	Tonsillitis	Chemotherapy
Heart Problems	RadiationTreatment	Tuberculosis

____CHECK HERE IF NONE OF THE ABOVE APPLY

Medications

List medications you are currently taking:

____
____
____

Allergies

Latex	Penicillin
Barbiturates (sleeping pills)	Sulfa
Local anesthetic	Codeine
Other___________	NONE

By signing below, I acknowledge that I have truthfully answered the above questions.

Patient's Signature____ Date __________________

Reviewed by____ Date __________________

Appointment Policy

Please remember that we have reserved appointment times especially for you. We understand things may arise where you have to change your appointment time. Allow at least 24 hours notice to inform us of your change. Frequent missed appointments or rescheduling will not be tolerated. Patients who do so will incur a $50 broken appointment fee and a loss of priority appointments.

______________________ ________
(signature) (date)

Insurance Policy

Our goal is to maximize your insurance benefits. Dental insurance does not always pay for everything and some require a yearly deductible and copays. Your estimated out-of-pocket expenses are due on the day of treatment. We agree to wait a reasonable period of time for the insurance company to pay for its portion. If the insurance company fails to pay after 60 days, you agree to pay the full balance due.

______________________ ________
(signature) (date)

Consent for Dental Treatment

Dr. Roderick Lucente will perform a complete evaluation of your dental condition. You consent to perform whatever is deemed necessary to diagnose and treat what has been planned. These may include the use of x-rays, local anesthesia, and other medications. You will be advised of the options for treatment and will have the opportunity to ask any questions. You, the patient, have a right to accept or reject dental treatment by the dentist, Dr. Lucente. You should carefully consider the anticipated benefits and commonly known risks of the recommended procedures, alternative treatments, or the option of no treatment.

______________________ ________
(signature) (date)

Acknowledgement of Receipt of Privacy Practices

I have reviewed the office's Notice of Privacy Practices (available upon request) and understand that I may request a copy by email or paper for my records at any time.

______________________ ________
(signature) (date)