

# LORI A. FITZGERALD DDS LLC

General Dentistry

5711 Shields Road

Canfield, Ohio 44406

Office: (330) 533-0804 Fax: (330) 533-0800



**Please Print And Fill Out All Pages Of This Form Completely In Ink.**

Patient # \_\_\_\_\_

*(For office use only.)*

Soc. Sec. # \_\_\_\_\_

Date \_\_\_\_\_

## Patient Information: (Confidential)

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

E-mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

Check appropriate space: Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

If student, name of school/college \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Full \_\_\_\_\_ Part \_\_\_\_\_

Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party:

Name of Person Responsible For This Account \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ State \_\_\_\_\_ Date of birth \_\_\_\_\_ Bank \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_

Is This Person Currently A Patient In Our Office? Yes \_\_\_\_\_ No \_\_\_\_\_

*For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.*

Cash  Check  Credit Card: VISA  MasterCard  I wish to discuss the office's payment policy

# Insurance

**Patient No.:** \_\_\_\_\_  
(For office use only.)

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Employer \_\_\_\_\_ Union/Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Empl. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Primary Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 How much is your deductible? \_\_\_\_\_ How much used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

**DO YOU HAVE ADDITIONAL INSURANCE? YES  NO  IF YES, COMPLETE THE FOLLOWING:**

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Employer \_\_\_\_\_ Union/Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Empl. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Additional Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 How much is your deductible? \_\_\_\_\_ How much used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

# Patient Medical History:

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of: Last Exam \_\_\_\_\_ Last X-ray \_\_\_\_\_

Are you under medical treatment now? ..... Yes No  
 Have you been hospitalized for any reason within the  
 last 5 years? ..... Yes No  
 If so, please explain \_\_\_\_\_  
 \_\_\_\_\_  
 Are you taking any medications, including  
 Non-prescription medicines? ..... Yes No  
 If so, what ones are you taking? \_\_\_\_\_  
 \_\_\_\_\_  
 Have you ever taken Fen-Phen/Redux? ..... Yes No  
 Do you use tobacco? ..... Yes No  
 Do you use controlled substances? ..... Yes No  
 Are you wearing contact lenses? ..... Yes No  
**Women Only:**  
 Are you pregnant or think you may be pregnant? .. Yes No  
 Are you nursing? ..... Yes No  
 Are you taking oral contraceptives? ..... Yes No

Do you have any allergies to:  
 Local Anesthetics (e.g. Novocain)..... Yes No  
 Penicillin or other Antibiotics. .... Yes No  
 Sulfa Drugs ..... Yes No  
 Barbiturates ..... Yes No  
 Sedatives ..... Yes No  
 Iodine..... Yes No  
 Aspirin ..... Yes No  
 Any metals (e.g. nickel, mercury, etc.) ..... Yes No  
 Latex Rubber..... Yes No  
 Others (please list) \_\_\_\_\_  
 \_\_\_\_\_  
 10. Do you have a persistent cough or throat clearing not  
 associated with a known illness (lasting more than 3  
 weeks)?..... Yes No

## Do You Have Or Have You Had Any Of The Following:

**Patient No.:** \_\_\_\_\_

*(For office use only).*

|                                   |            |           |
|-----------------------------------|------------|-----------|
| <b>Rheumatic Fever ----</b>       | <b>Yes</b> | <b>No</b> |
| <b>Heart Murmur ----</b>          | <b>Yes</b> | <b>No</b> |
| <b>Joint Replacement ----</b>     | <b>Yes</b> | <b>No</b> |
| <b>Mitral Valve Prolapse ----</b> | <b>Yes</b> | <b>No</b> |

|                                |     |    |
|--------------------------------|-----|----|
| Fainting / Seizures ---- . .   | Yes | No |
| Asthma ---- . .                | Yes | No |
| Low Blood Pressure ---- . .    | Yes | No |
| Epilepsy / Convulsions --- . . | Yes | No |
| Leukemia ---- . .              | Yes | No |
| Diabetes ---- . .              | Yes | No |
| Kidney Diseases ---- . .       | Yes | No |
| Aids or HIV Infection ---- . . | Yes | No |

|                              |     |    |
|------------------------------|-----|----|
| Thyroid Problems ---- . .    | Yes | No |
| Heart Disease --- . .        | Yes | No |
| Cardiac Pacemaker ---- . .   | Yes | No |
| High Blood Pressure ---- . . | Yes | No |
| Angina ---- . .              | Yes | No |
| Frequently Tired ---- . .    | Yes | No |
| Anemia ---- . .              | Yes | No |
| Emphysema ---- . .           | Yes | No |
| Cancer ---- . .              | Yes | No |
| Arthritis ---- . .           | Yes | No |
| Heart Attack ---- . .        | Yes | No |
| Hepatitis / Jaundice --- . . | Yes | No |
| STD's ---- . .               | Yes | No |
| Stomach Ulcers ---- . .      | Yes | No |

|                                |     |    |
|--------------------------------|-----|----|
| Chest Pains ---- . .           | Yes | No |
| Easily Winded ---- . .         | Yes | No |
| Stroke ---- . .                | Yes | No |
| Hay Fever / Allergies ---- . . | Yes | No |
| Tuberculosis ---- . .          | Yes | No |
| Radiation Therapy ---- . .     | Yes | No |
| Glaucoma ---- . .              | Yes | No |
| Recent Weight Loss ---- . .    | Yes | No |
| Liver Disease ---- . .         | Yes | No |
| Heart Trouble ---- . .         | Yes | No |
| Respiratory Problems ---- . .  | Yes | No |
| Swollen Ankles ---- . .        | Yes | No |
| Other ---- . .                 | Yes | No |

## Patient Dental History:

Previous Dentist: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Location: \_\_\_\_\_ Date Last Exam: \_\_\_\_\_

|   |     |    |
|---|-----|----|
| Do your gums bleed while brushing or flossing? .....                | Yes | No |
| Are your teeth sensitive to hot or cold liquids/food?.....          | Yes | No |
| Are your teeth sensitive to sweet or sour liquids/foods? ....       | Yes | No |
| Do you feel pain to any of your teeth?.....                         | Yes | No |
| Do you have sores or lumps in or near your mouth?.....              | Yes | No |
| Do you have any head, neck or jaw injuries?.....                    | Yes | No |
| Have ever experienced any of the following problems<br>in your jaw: |     |    |
| Clicking .....  | Yes | No |
| Pain (Joint, ear, side of face).....                                | Yes | No |
| Difficulty in opening or closing .....                              | Yes | No |
| Difficulty in chewing .....   | Yes | No |

|   |     |    |
|---|-----|----|
| Do you have frequent headaches? .....   | Yes | No |
| Do you clench or grind your teeth? .....  | Yes | No |
| Do you bite your lips or cheeks frequently? ....  | Yes | No |
| Have you ever had any difficult extractions<br>in the past? .....                                   | Yes | No |
| Have you ever had any prolonged bleeding<br>following an extraction? .....                          | Yes | No |
| Have you had any orthodontic treatment? .....   | Yes | No |
| Do you wear dentures or partials? .....   | Yes | No |
| Have you ever received oral hygiene instructions<br>regarding the care of your teeth and gums? .... | Yes | No |
| Do you like your smile? .....   | Yes | No |

**Authorization and Release:**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my designated dependents.

**X** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
*Signature of patient (or parent/guardian if minor)*

**Doctor's Comments:**

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**X** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
*(Doctor's signature)*

Patient No.: \_\_\_\_\_  
(For office use only.)

(Acknowledgement of)

**Notice Of Privacy Practices**

Lori A. Fitzgerald DDS LLC

5711 Shields Road  
Canfield, Ohio 44406  
Office: (330) 533 – 0804 Fax: (330) 533 - 0800

I understand that, under the Health Insurance Portability and Accountability 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:

- 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.
- Obtain payment from third-party payers.
- Conduct normal health care operations, such as quality assessments and physician certification.

I acknowledge that a copy of **Notice of Privacy Practices** is available to me upon request, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization anytime at the above address to obtain a current copy of such **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 or health-care operations. I also understand 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 Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(For Office use only.)

I attempted to obtain the Patient's signature in acknowledgement of the above affidavit, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_