

PATIENT REGISTRATION FORM

Today's Date: _____		PATIENT INFORMATION	
Last Name: _____	First (Legal) Name: _____	Middle Initial: _____	
Preferred Name: _____	Preferred Method of Contact: <input type="radio"/> Email	<input type="radio"/> Phone	<input type="radio"/> Text
Address (NO PO BOX): _____			
City: _____	State: _____	Zip: _____	
Mailing Address (if different from above): _____			
Date of Birth: _____	Age: _____	Social Security #: _____	
Email Address: _____			
Home Phone #: _____	Cell #: _____		
How did you hear about us? _____		Referred By: _____	
Sex: <input type="radio"/> Male <input type="radio"/> Female	Driver's License #: _____	State Issued: _____	
Marital Status: <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widowed			
Employer Name: _____	Work Phone #: _____	Ext: _____	
Employer (Work) Address: _____			

RESPONSIBLE PARTY INFORMATION			
Relationship to Patient: <input type="radio"/> Parent <input type="radio"/> Spouse <input type="radio"/> Self <input type="radio"/> Other	Sex: <input type="radio"/> Male <input type="radio"/> Female		
Last Name: _____	First (Legal) Name: _____	Middle Initial: _____	
Address (NO PO BOX): _____			
City: _____	State: _____	Zip: _____	
Best Contact Phone #: _____	Social Security #: _____		
Date of Birth: _____	Email Address: _____		

PRIMARY INSURANCE INFORMATION			
Name of Insured (Policy Holder): _____	Insured's Date of Birth: _____		
Insured's Social Security #: _____	Employer Name: _____		
Patient's Relationship to Insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other			
Insurance Company: _____	Phone #: _____		
Claims Mailing Address: _____			
Subscriber/Member/ID #: _____	Group #: _____		

# RUSSO DDS

LEESVILLE DENTAL CARE

Justin M. Russo, DDS, PLLC

## **Patient Dental History**

What is the main reason for your visit today?

Cleaning \_\_\_\_\_ Tooth Pain \_\_\_\_\_ Sensitivity \_\_\_\_\_ Whitening \_\_\_\_\_

Fresher Breath \_\_\_\_\_ Implants \_\_\_\_\_ Dentures \_\_\_\_\_

Other/Comments:

\_\_\_\_\_  
\_\_\_\_\_

**When was your last dental cleaning?** \_\_\_\_\_

Do you like the appearance of your smile? Yes \_\_\_\_\_ No \_\_\_\_\_

What changes (if any) would you like to make about your teeth?

\_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

Do you floss your teeth? Yes \_\_\_\_\_ No \_\_\_\_\_ How often? \_\_\_\_\_

Do you have bleeding gums? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you find yourself clenching or grinding your teeth? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had gum treatments, deep cleanings or scaling and root planing? Yes \_\_\_\_ No \_\_\_\_

What is your main concern with dental treatment?

Cost \_\_\_\_\_ Location \_\_\_\_\_ Comfort \_\_\_\_\_ Quality of Treatment \_\_\_\_\_

Practice Staff \_\_\_\_\_ Office Cleanliness \_\_\_\_\_ Other: \_\_\_\_\_

*Revised 8/5/2015*

Time 3:40 PM

Justin M. Russo, DDS, PLLC

Date 9/6/2016

**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?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> 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

Other?

If yes

Do you use controlled substances?

Yes  No

If yes

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

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

RUSSO DDS  
LEESVILLE DENTAL CARE

JUSTIN M. RUSSO DDS, PLLC  
13220 STRICKLAND ROAD, SUITE 166  
RALEIGH, NC 27613  
(919) 890-5147

I, \_\_\_\_\_, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.
5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

\_\_\_\_\_  
Patient or Guardian Name

\_\_\_\_\_  
Date



## **Justin M. Russo, DDS, PLLC Financial Policy**

In our practice, our foremost concern is patient care. We strongly believe that financial concerns should not be an obstacle to obtaining dental services necessary to restoring and/or preserving good oral health. We are sensitive to the fact that our patients have different needs in fulfilling their financial obligations.

### **PAYMENT & FEES**

- **WE ACCEPT: Cash, Cashier's Checks, Money Orders, Visa, M/C, Discover & American Express.** If you do not have dental insurance, or if you choose to file claims for treatment yourself, you must pay 100% of the charges at the time services are rendered.
- **PAYMENT PLANS:** If you should need a payment plan, our practice accepts **Care Credit** and **Lending Club** which offer monthly payment plans, often at 0% interest, upon application approval. We will be happy to assist you with the application process and answer any questions you may have.
- **APPOINTMENTS:** Appointment times are **reserved for you**. Please arrive on time so that we may provide the attentive service you deserve. *If you are more than 10 minutes late, we may have to reschedule in order to have enough time for your treatment.*
- **BROKEN APPOINTMENTS:** Appointments that are cancelled or rescheduled without 48 hour notice or scheduled appointments that you do not keep ('no show') will be charged a fee of \$50.00 or 10% of the total scheduled treatment cost, whichever is greater. *This fee is subject to change at the practice's discretion.*
- **DELINQUENT ACCOUNTS:** Accounts over 90 days are subject to interest at 3% per month.
- **RETURNED CHECKS:** Will be assessed a \$50.00 fee plus any other fees incurred by our financial institution.

***\*Patient/Guardian Initial here \_\_\_\_\_***

**FINANCIAL OBLIGATIONS RELATED TO PATIENTS WITH INSURANCE**

Dental “insurance” differs than that of medical insurance. Your dental benefit is an agreement between your employer, dental carrier and you the patient. We file insurance claims as a courtesy to our patients. While we do our best to verify coverage for all services rendered, **YOU AS THE POLICY HOLDER ARE ULTIMATELY FINANCIALLY RESPONSIBLE FOR UNDERSTANDING THE BENEFITS AND LIMITATIONS OF YOUR COVERAGE.**

Because plans differ in coverage, **please check with your employer and/or the insurance company regarding the specifics of YOUR benefits.** Most insurance companies have strict limitations related to the timing and frequency of covered procedures, so we encourage you to educate yourself as much as possible on this subject.

**\*\*YOU ARE RESPONSIBLE FOR ANY/ALL SERVICES NOT COVERED BY YOUR INSURANCE**, including but not limited to co-payments, deductibles, and non-covered services. In cases where non-covered services are rendered, you are responsible to pay 100% of these charges at the time services are rendered. Any treatment fees quoted to you during a visit are **ONLY AN ESTIMATE** of what is reported to us by your dental carrier, which is **NOT A GUARANTEE OF PAYMENT ON THE SERVICE/PROCEDURE**. You will receive a statement for any remaining amount owed once the claim is processed. *If your insurance has not paid the balance due after 60 days from the date of service, you are responsible for that amount.* After 90 days, a finance charge may be added or the account may be turned over to a collection agency.

*\*Patient/Guardian Initial here \_\_\_\_\_*

**ACKNOWLEDGEMENT**

I hereby acknowledge that I have read, understand, and agree to adhere to the practice’s Financial Policy as outlined above. *\*Please note that whichever parent accompanies the minor patient to their appointment and signs the financial agreement will be considered the responsible party for the minor’s account.*

**Patient’s signature** \_\_\_\_\_

**Guardian’s signature (if patient is <18 yo)** \_\_\_\_\_

**Date** \_\_\_\_\_

If you are representing a minor patient or are the parent, please complete the following:

**Patient’s Name** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

**Print Guardian’s name** \_\_\_\_\_

# RUSSO DDS

LEESVILLE DENTAL CARE

*Leesville Dental Care* is proud of the quality of patient care we provide. We try our best to respect each patient's time and we ask the same in return. Because we will not compromise the service and quality of patient care, please read our policy below carefully.

## **CANCELLATION OF AN APPOINTMENT**

In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. **Any appointment(s) not cancelled 2 business days in advance is subject to a \$50.00 cancellation fee or a charge of 10% of your scheduled treatment total, whichever is greater.**

## **NO SHOW POLICY**

A no show is an appointment that was not cancelled in advance. No shows inconvenience other patients who need dental care. **Therefore, if you no show for a scheduled appointment you will be charged a fee of \$50.00 or 10% of your scheduled treatment total, whichever is greater.**

## **DEPOSITS REQUIRED FOR SCHEDULED SERVICES**

Please be advised that a deposit is required for any scheduled treatment over \$500.00. The deposit will be applied towards your out-of-pocket expense and reserves the date and time for your treatment.

I have read and agree to this policy.

Patient Name \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES**

**LEESVILLE DENTAL CARE**

**13220 Strickland Road, Suite 166 / Raleigh, NC 27613**

**Acknowledgement**

- I, \_\_\_\_\_, hereby acknowledge that I have received and/or reviewed a copy of **Leesville Dental Care's HIPAA Notice of Privacy Practices**.

I understand that **Leesville Dental Care's HIPAA Notice of Privacy Practices** may change periodically and that I am entitled to receive a copy of **Leesville Dental Care's revised HIPAA Notice of Privacy Practices** upon request. I understand that, if I have questions about **Leesville Dental Care's HIPAA Notice of Privacy Practices**, I may contact:

Justin M. Russo, DDS, PLLC  
 13220 Strickland Rd, Suite 166  
 Raleigh, NC 27613  
 Phone: (919) 890-5147  
 Fax: (919) 890-5953  
 Email: [frontdesk@leesvilledentalcare.com](mailto:frontdesk@leesvilledentalcare.com)

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Leesville Dental Care** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Leesville Dental Care's** privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask **Justin M. Russo, DDS, PLLC** noted above, for assistance.

Patient Signature	Date
Signature of Parent / Guardian	Print Name of Parent / Guardian
	Relationship to Patient

**FOR OFFICE USE ONLY**

**Leesville Dental Care** made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Leesville Dental Care was unable to obtain a signed Acknowledgement for the following reason(s):

- Refusal to sign Acknowledgement on \_\_\_\_\_, 20\_\_\_\_\_.
- Communication barriers prohibited us from obtaining a signed Acknowledgement.
- An emergency situation prohibited us from obtaining a signed Acknowledgement.
- Other (Describe): \_\_\_\_\_

Date Received	Received By	Patient ID