FRANKLIN DENTAL CARE

John P. Giannopoulos, D.D.S.

WELCOME!

Thank you for selecting our dental

healthcare office.

We will strive to provide you with the best possible dental care. To help us meet all your dental health care needs, please fill out this form completely. If you have any questions or need assistance, please ask us--- we'll be happy to help.

Patient Information

Date: _____

Name: Mr. Mrs. Ms. First: _____ Last: _____

Social Security #_____ Birthday_____ Home Phone#_____

Home Address _____ City_____ State _____ Zip Code _____

Cell Phone #_____ Work Phone#_____ Email:_____

Best way to reach you during the day? _____ Driver's Licenses or State ID# _____

Check appropriate Box: [ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Student

If minor, Parent or Guardian name: First_____ Last:_____

School/College_____ City_____ State_____

How did you hear about us?_____

Person to contact in case of emergency_____ Phone #_____

Responsible Party (other than patient)

Name of Person Responsible for This Account_____

Relationship to you_____ Home Phone: _____ Work Phone: _____

Social Security #_____ Date of Birth: _____

Address_____ City: _____ State:_____ Zip:_____

Is This Person Currently a Patient in Our Office? ____ Yes ____ No

Dental Insurance Information

Name of insured_____ Id #_____ Birth Date: _____

Name of employer & address_____

City/State_____ Zip Code_____ Work Phone: (___)_____

Insurance Company Name: _____ Phone #_____ Group#_____

Have you used any of your benefits this year? ____Yes ____No If yes, how much?_____

Your Initials_____

Patient Medical History

Physician:_____ Office Phone: _____Date of Last Exam:_____

1. **Do you have or have you had any of the following?**

High Blood Pressure	Yes No	Heart Disease	Yes No	Epilepsy/Convulsions	Yes No
Low Blood Pressure	Yes No	Coronary Artery Stent	Yes No	Liver Disease	Yes No
Rheumatic Fever	Yes No	Cardiac Pacemaker	Yes No	Hepatitis/Jaundice	Yes No
Swollen Ankles	Yes No	Stroke	Yes No	Frequently Tired	Yes No
Fainting/Seizures	Yes No	Mitral Valve Prolapsed	Yes No	Kidney Disease	Yes No
Hay Fever	Yes No	High Cholesterol	Yes No	Thyroid Problems	Yes No
Anemia	Yes No	Emphysema	Yes No	Joint Replacement or Implants	Yes No
Tuberculosis	Yes No	Respiratory Problems	Yes No	Sexually Transmitted Disease	Yes No
Glaucoma	Yes No	Leukemia	Yes No	Stomach Troubles/Ulcers	Yes No
Arthritis	Yes No	Cancer	Yes No	Other:_____	
Diabetes	Yes No	Radiation Therapy	Yes No		
AIDS or HIV Infection	Yes No	Bisphosphonate Therapy	Yes No		
Asthma	Yes No				

1. Are you under medical treatment now? Yes No
2. Have you been hospitalized for surgery or seriously ill within the last 5 years? Yes No
4. Are you taking any medications including nonprescription medications? Yes No
   If yes, which medications are you taking?
   _____
5. Have you ever taken Phen-Fen/Redux? Yes No
6. Do you use tobacco? Yes No
7. Do you use controlled substances? Yes No
8. **Women only:**
   Are you, or do you think you may be pregnant? Yes No
   Are you nursing? Yes No
   Are you taking oral contraceptives? Yes No

9. **Are you allergic to or have you had any reaction to:**

Latex Rubber	Yes No
Local Anesthetics (e.g. Novocain)	Yes No
Penicillin or other antibiotics	Yes No
Sulfa Drugs	Yes No
Barbiturates	Yes No
Any Metals (e.g. nickel, mercury)	Yes No
Sedatives	Yes No
Iodide	Yes No
Aspirin	Yes No
Other:_____	

10. Do you have or have you had any disease, condition, or problem not listed? Yes No
    If yes, please explain: _____

Patient Dental History

Name of previous Dentist and Location: _____ Date of last Exam: _____

1. Do your gums bleed while brushing of flossing? Yes No
2. Are your teeth sensitive to hot or cold Yes No
3. Are your teeth sensitive to sweet or sour? Yes No
4. Do you have any tooth pain? Yes No
5. Do you have sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you ever experienced any of the following problems in your jaw:
   - Clicking Yes No
   - Pain (joint, ear, side of face) Yes No
   - Difficulty in opening and closing Yes No
   - Difficulty chewing Yes No
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
10. Do you bite your lips or cheeks? Yes No
11. Have you ever had a difficult extraction? Yes No
12. Have you ever had prolonged bleeding following an extraction? Yes No
13. Have you had any orthodontic treatment? Yes No
14. Do you wear dentures or partials? Yes No
    If yes, date of placement: _____
15. Have you received oral hygiene instructions regarding the care of your teeth and gums? Yes No

_____ _____
Patient/Parent Signature Date

Smile Questionnaire

Please rate your smile on a scale of 1 to 10 with 10 being the best.

1 **2** **3** **4** **5** **6** **7** **8** **9** **10**

If you had a magic wand, what would you change about the appearance of your teeth and smile?

Whiter Straighter Longer Shorter
Less Crowded Close the Gaps Less "gummy" Smile
Other _____

OUR OFFICE FINANCIAL POLICY

It is customary for us to receive full payment at the time of the appointment for the INTIAL EXAMINATION and CONSULTATION appointment , as well as for the EMERGENCY VISITS. When extensive treatment is planned, requiring multiple appointments, we realize it may be necessary to make other arrangements before the treatment is scheduled.

How will you be paying for your treatment? Please circle one:
Cash **Check** **Credit Card** **Debit Card**

For patients with a dental benefit covering part of the treatment cost:

Dental benefits are a money benefit typically provided by an employer to help their employees pay for routine dental treatment. Most benefit plans are only designed to cover a portion of the cost. We ask for your co-payment for each service at the time it is rendered.

As a courtesy to our patients with dental benefits we will:

1. Complete your claim form and submit them to your carrier within 24 hours of treatment.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your primary carrier.
4. If necessary, re-file your claim a second time within 60 day period.

Patient Responsibilities

1. Pay fees not covered by your plan at the time of treatment.
2. Proved our office with correct information regarding your benefit plan.
3. In the event that you may be covered by two dental benefit plans, we will await payment from your primary plan, but ask that your secondary plan reimburse you directly.
1. Understand that your plan is between you and your employer and carrier. Our office does not have the power to make your plan pay.
2. Pay any account balance not covered by your benefit plan, or not received by our office within 60 day of treatment.

In the event of an outstanding balance a 1.5% finance charge will be assessed monthly. Also, we reserve the right to charge a fee for missed appointments if not given at least 48 hours notice of cancellation.

Our staff is responsible for scheduling your appointments and completing your financial arrangement. They will sincerely consider your needs in each of these areas and make special arrangements if necessary. If you have any questions about the above, please do not hesitate to consult with them. Thank you for your cooperation.

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of changes in dental benefits, address, phone numbers, and medical conditions. I have read and understand the above policy and fully intend to stand by the financial arrangements made with the office.

Signature (parent if minor)_____ **Date**_____

Notice of Privacy Practices

This notice describes our medical/protected health information about you, how it may be used and disclosed and how you can get access to this information. Please review it carefully.

Summary:
By law, we are required to provide you with our notice of privacy practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

- The right to inspect and copy your information.
- The right to request corrections to your information.
- The right to request that your information be restricted.
- The right to request confidential communications.
- The right to a report of disclosure of your information.
- The right to a paper copy of this notice.

We want to assure you that your medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private.

If you have any questions about this notice, please contact our office.

Acknowledge of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this Practice's Notice of Privacy Practices, and understand that if I have questions or complaints regarding my privacy rights that I may contact this office at the number listed above, I further understand that the practice will offer me updates to this Notice of Privacy Practices should
this be amended, modified, or change in any way.

_____	_____	_____
Print Name (parent or guardian)	**Signature** (parent or guardian)	Date

Patient refused to sign
Patient was unable to sign because_____