Welcome

L.I. Periodontics & Dental Implants, PLLC
Dr. Jeffrey Rosario / Dr. Caroline Rubino / Dr. Julio Carrion

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

Patient Information

Today's date_____ Home Phone (_____)_____ Cell Phone (_____)_____
First name _____ Middle Initial _____ Last Name _____SSN#_____
Address _____ City _____ State _____ Zip _____
Sex ☐M ☐F Date of Birth_____ ☐ Married ☐ Widowed ☐ Divorced ☐ Single ☐ Minor
Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone (____)_____
Whom may we thank you for referring you? _____
In case of emergency who should be notified? _____ Phone (_____)_____

Primary Dental Insurance

Person Responsible for account _____
Last Name First Name Middle Initial
Relation to patient _____ Date of Birth _____ ID#/Soc. Sec. #_____-_____-_____
Address (if different from patient's) _____ Phone (_____)_____
Person Responsible Employed By _____ Occupation _____
Business Address _____ Business Phone (_____)_____
Insurance Company _____ Subscriber # _____ Group # _____
Names of other dependents covered under this plan _____

Additional Dental Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber Name _____ Relation to Patient _____ DOB_____
Address (if different from patient's) _____ Phone (_____)_____
Person Responsible Employed By _____ Occupation _____
Business Address _____ Business Phone (_____)_____
Insurance Company _____ Subscriber # _____ Group # _____
Names of other dependents covered under this plan _____

Please Complete Both Sides

Dental History

Reason for today's visit _____ Date of last dental care _____

General Dentist (Present)_____ Date of last dental x-rays _____

Dentist Address _____ Dentist Phone (_____)_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No Are you currently in pain? ☐ Yes ☐ No

Check (√) if you have had problems with any of the following:

☐ Bad breath ☐ Grinding teeth ☐ loose teeth or broken fillings ☐ Bleeding gums

☐ Clicking or popping jaw ☐ Food collection between teeth ☐sensitivity to cold, heat or sweet

☐Have you ever had periodontal disease? ☐ Have you ever had gum treatment?

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? ☐ Yes ☐ No

Have you had any serious illness or operations? ☐ Yes ☐ No If yes, describe? _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (√) if you have or have had (please give approximate dates) any of the following:

☐ AIDS
☐ Anemia
☐Arthritis/Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐Blood Transfusion
☐ Blood Disease
☐ Cancer/Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatment
☐ Chronic Cough
☐ Diabetes
☐ Epilepsy or Seizures
☐ Frequent Headaches
☐ Hay Fever
☐Heart (Surgery, Disease, Attack)
☐ Heart Pacemaker
☐Heart Murmur
☐ Hemophilia/Abnormal Bleeding
☐ Hepatitis A B C (circle)
☐ High Blood Pressure
☐Kidney Disease
☐Liver Disease
☐ Mitral Valve Prolapse
☐ Nervous/Anxious
☐ Radiation Therapy
☐ Respiratory Disease
☐ Rheumatic/Scarlet Fever
☐ Sinus Trouble
☐ Shortness of Breath
☐ Stroke
☐Swelling of Feet/Ankles
☐ Thyroid Problems
☐ Tuberculosis (TB)
☐Tumors
☐ Ulcers
☐ Venereal Disease

Pharmacy Name: _____ Pharmacy Address: _____

Medications: _____ Allergies: _____

_____ _____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.