DOMENIC BAGLIVO, JR., D.M.D.

dmd5759@gmail.com

100 E. Lancaster Avenue | Lankenau Hospital, Suite 203 • Wynnewood, PA 19096 (610)642-0259

Welcome to our Practice

Chart#:

FOR OFFICE USE ONLY

Patient Name:

Last First MI

Preferred Name

Title: **Gender:** ○ Male ○ Female

Mr/Ms/Mrs/etc

Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date:

SS#: ___-__-____

Prev. Visit:

Email Address:

Best time to call: **Phone:**

Home Mobile

Work Ext Fax Other

Address:

Address 1

Address 2

City

State Zip Code

Employment Information

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____

Phone: _____

Employer Address:

_____
Address 1

_____
Address 2

_____ _____
City State

_____-____
Zip Code

Second Employer (if applicable)

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____

Phone: _____

Employer Address:

_____
Address 1

_____
Address 2

_____ _____
City State

_____-____
Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for:

○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name:

Last First MI

Preferred Name

Title: **Gender:** ○ Male ○ Female

Mr/Ms/Mrs/etc

Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date:

SS#: **DL#:** ___-__-____

Email Address:

Best time to call: **Phone:**

Home Mobile

Work Ext Fax Other

Address:

Address 1

Address 2

City

State Zip Code

Primary Dental Insurance:

Name of Insured:

Last

First MI

Insured's Birth Date:

ID #: **Group #:**

Insured's Address:

Address 1

Address 2

City State

_____-____

Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City State

_____-____

Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City State

_____-____

Zip Code

Insurance Company Phone Number:

Secondary Dental Insurance (if applicable)

Name of Insured:

Last

First MI

Insured's Birth Date:

ID #: **Group #:**

Insured's Address:

Address 1

Address 2

City State

Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City State

Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City State

Zip Code

Insurance Company Phone Number:

Primary and Secondary Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges if not covered by insurance.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

_____

_____

Date of most recent dental exam and dental x-rays:

_____

_____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Is there anything about the appearance of your smile that you would like to change?

_____

_____

Check all that apply:

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ You experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Have you ever whitened or bleached your teeth
☐ Have you experienced popping and/or clicking of your jaw joint
☐ You have difficulty chewing
☐ You clench or grind your teeth
☐ You wear or have worn a bite appliance
☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ Experienced gum recession
☐ Had any teeth become loose on their own (without injury)
☐ Experienced a burning sensation in your mouth
☐ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made prior to arrival for treatment.

I hereby authorize the office of Domenic Baglivo Jr., D.M.D. to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my insurance carrier. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Dr. Domenic Baglivo. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim. I understand that if I do not have dental insurance payment is due at the time of service as per office policy. This authorization will be valid for one year from date of signature. A photocopy of this document may act as an original.

We have installed a state of the art computer system that includes the ability to obtain ESTIMATED dental benefits based on our office fees. You are expected to pay your estimated portion at the time services are rendered unless other arrangements have been made in advance. Please note that due to differences between individual service plans we are unable to determine in advance the actual final payment from your dental insurance company. Therefore, upon final receipt of final payment from your insurance company, in the case of overpayment, your account will be credited and upon your request a refund check will be issued. In the event of an underpayment, we will generate a billing statement for the unpaid balance. Finally it is important to remember, services are provided to you and not to your insurance company. You are financially responsible for all services provided.

A $30 charge for all missed appointments will be added to your account. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 hours in advance.

Our doctor and hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. There will be a fee of $30.00 assessed if we do not receive a call to cancel an appointment.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused

appointments to better serve the needs of all patients.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the cancellation policy.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I hereby give my permission to the person(s) listed below to receive information about my care.

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: _____