Vinciguerra & Mathew

Patient Information

Patient Name: _____ Date: *07/21/2022*
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____ Best time to call: _____

Address: _____
Street Apartment #

«City» *«State»* *«Zip»*

Email Address_____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

OTHER:
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____

- Name of Physician: _____ Phone: _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain

Please list all medications you are currently taking_____

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient _____ ☐ Google ☐ Facebook ☐ Other _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____ ☐ Male ☐ Female

Social Security #: _____ Birth Date: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Insurance Carrier Name: _____

ID #: _____ Insurance Phone Number: _____

Secondary

Insurance Carrier Name: _____

ID #: _____ Insurance Phone Number: _____

Pharmacy Information

Pharmacy Name: _____

Address: _____

_____

Phone Number: _____

To the best of my knowledge, all the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next appointment without fail.

Assignment of Benefits & Authorization to Release Medical/Dental Information:

I certify that all information is true and correct. I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or any other diagnostic aids deemed appropriate. I authorize and direct Sheryl Silverstein DMD & Michael Vinciguerra DDS, LLP, having treated me, to release to governmental agencies, Insurance carriers or others who are financially liable for my medical/dental care, all information needed to substantiate payment for such medical/dental care and representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to Sheryl Silverstein DMD & Michael Vinciguerra DDS, LLP sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical/dental care to cover the costs of the care and treatment rendered to myself of my dependents. I request that payment of authorized benefits be made on my behalf, and understand I am responsible for charges not covered by my policy or plan. In consideration of services rendered by Sheryl Silverstein DMD & Michael Vinciguerra DDS, LLP to the undersigned patient, the undersigned promises to pay Sheryl Silverstein DMD & Michael Vinciguerra DDS, LLP any co-payment, co-insurance or other charges required to be paid by my dental insurance coverage. In addition I promise to pay for all services that are not covered by my dental insurance plan.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
A service charge of 1½% 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.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Dental insurance was not designed to pay for all dental care, most contracts have limits and/or various degrees of co-payment. **The dental insurance policy is between the insurance company and the patient, whom bears the ultimate financial responsibility.**

I have read the above conditions of treatment and payment and agree to their content.

I have received and read a copy of the Privacy Practices of Sheryl Silverstein DMD & Michael Vinciguerra DDS, LLP.

Signature _____ **Date** _____

GENERAL DENTISTRY INFORMATION FORM

Dentist: Sheryl Silversten D.M.D. & Michael Vinciguerra D.D.S. LLP

Dentistry is not an exact science and reputable practitioners cannot properly guarantee results. Despite the most diligent care and precaution, unanticipated complications or unintended results, although rare, may occur. Guarantees and assurances cannot be made by anyone regarding the dental treatment which you have requested and authorized. It is essential that you keep your appointments and cooperate in your treatment to help ensure the best possible result. Please read the following and initial and sign where noted.

SERVICES THAT MAY BE PROVIDED INCLUDE THE FOLLOWING:

1. DRUGS, MEDICATIONS, AND ANESTHETICS Antibiotics, analgesics, and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock. It is your responsibility to alert us of any known allergies. Injections of local anesthetics can cause paresthesia (numbness) of teeth, lips, and surrounding tissues. Though quite rare, this numbness can sometimes be permanent. It is recommended that you do not chew on food until anesthetics wear off to prevent biting of the cheek and tongue. Studies have shown that Bisphosponate (ex. Fosomax) therapy for osteoporosis can actually cause bone loss in the jawbone, which can consequently compromise certain dental treatments.
2. FILLINGS This office is mercury free. To prevent using a potentially toxic alloy, a composite, bonded resin (tooth colored) filling material is generally used unless otherwise requested. Additional charges may be incurred. Care must be exercised in chewing on filled teeth, especially on large fillings to avoid breakage. A more extensive restorative procedure than originally diagnosed may be necessary, due to more decay than anticipated and/or compromise of tooth structure. Sensitivity can occur following a newly placed filling and will usually go away with time.
3. CROWNS, BRIDGES AND LAMINATES These restorations involve permanent alteration of the tooth structure. It is not always possible to match the color of the natural teeth exactly with artificial teeth. Temporary interim restorations may come off easily. Care must be taken to insure that they are kept on until the permanent restorations are delivered. The final opportunity to make changes to the new crown(s), bridge(s), or laminates(s) (including the shape, fit, size, and color) will be before cementation. It is necessary to keep the appointment for permanent cementation in a timely manner. Excessive delays may allow for tooth movement, or changes in gum tissue necessitating the remaking of the restoration and additional charges may be incurred.
4. DENTURES (FULL AND PARTIAL) The wearing of dentures can be difficult. Sore spots, altered speech, and difficulty in eating are common problems. Due to loss of jaw ridge, retention of full dentures can be a problem. Immediate, interim dentures may require considerable adjusting and several relines. A long term appliance and/or reline will be needed at a later time (this is not included with the immediate denture fee). You are responsible to return for delivery of the dentures in a timely manner. Failure to do so may result in poorly fitting dentures and remakes will require additional charges. Failure to war partial dentures daily will likely lead to tooth movement, resulting in a partial that no longer fits.
5. PERIODONTAL DISEASE Periodontal disease affects the gums and bone which support the teeth. It is a serious, progressive infection causing breakdown of the gums and bone and eventual loss of teeth. It is best treated in its early stage. Treatment options may include gum surgery, extractions, and replacements. Undertaking any dental procedure may have adverse effect on the periodontia.
6. ENDODONTIC TREATMENT (ROOT CANAL) Although over 90% effective, there is no guarantee that root canal treatment will succeed and complications can occur from treatment. Occasionally, root canal material may extend beyond the root tip, which does not necessarily affect the success of treatment. Endodontic files and reamers are very fine instruments that can separate during use. If complications arise during or following treatment, referral to a specialist may be needed requiring further treatment and additional cost. Additional procedures may be necessary following root canal treatment to ensure optimal prognosis of the tooth. A posterior, endodontically treated teeth require crowns to minimize the chance of the tooth breaking. Despite all efforts to save it, the tooth may still be lost.
7. REMOVAL OF TEETH (EXTRACTIONS) Teeth may need to be extracted for various reasons, such as non-restorability, lack of bone support, part of orthodontic treatment, impactions, and infections etc. There are alternatives to the removal of treatable teeth and these options include root canal treatment, periodontal treatment, and crowns. Removal of teeth does not always remove the infection, if present, and further treatment may be necessary. There are risks involved in having teeth removed, including, but not limited to pain, swelling, spread of infection, dry socket, loss of feeling in the teeth, lips, tongue, and surrounding tissues (that can last for an indefinite period of time) and jaw fracture. If complications arise during or following treatment, referral to a specialist may be needed requiring further treatment and additional cost.
8. CHANGES IN TREATMENT PLAN A treatment plan is based on the best evidence available during the examination. There is no guarantee that this plan will not change. During treatment, it may be necessary to change or add procedures because of conditions that were not evident during examination, but were found during the course of treatment. For example, root canal treatment may become necessary during routine restorative procedures.

Signature_____ Date _____

Relationship to Patient _____