Lakeville Perio & Implant/ Dr. Gabriela Ciornei - PATIENT REGISTRATION

First Name: ____________________ Last Name: ____________________ Middle Initial: ______

Address: ____________________ E-mail Address: ____________________

City, State, Zip: ____________________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

Sex: ☐ Female ☐ Male ☐ Other Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth date: ____________________ **Social Security #:** ____________________ Drivers Lic #: ____________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ F/T or P/T Student

Pharmacy – Phone Number - Address: ____________________

Referred By: ☐ Internet ☐ Other Patient ☐ Employer ☐ Other ____________________

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Responsible Party for Payment: ☐ **SAME AS ABOVE** Relationship to patient: ____________________

First Name: ____________________ Last Name: ____________________ Middle Initial: ______

Address: ____________________

City, State, Zip: ____________________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

Birth date: ____________________ **Social Security #:** ____________________ Drivers Lic #: ____________________

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Dental Insurance Information: ____________________

Policy Holder Name: ____________________ Employer: ____________________

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Parent Insurance Company ____________________

Policy/Group# ____________________ Address ____________________

Subscriber ID# ____________________ Ins. Co. Phone # ____________________

Insured Social Security# ____________________

Insured Birth Date ____________________

Time 3:53 PM

Lakeville Perio Implant _Dental Surgery

Date 10/19/2023

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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

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

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

Have you ever had any serious illness not listed above? ◯ 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:_____

Dr. Gabriela Ciornei D.D.S
3517 Thomas Drive Suite 12
Lakeville, NY 14480
(585)346-7408
Lakevilleperio14480@gmail.com

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient Name (Print):_____Date:_____

We are pleased to assist you with any dental insurance. If you have dental insurance, please be aware that insurance quotes are an **ESTIMATE** only. Coverage may be different if your deductible has not been met, annual maximum has been met, or if your coverage table is lower than average.

• The patient (or patient's parent or guardian, if under the age of 18) is fully responsible for payment of care regardless of if you have insurance or not.

• I understand that this office does not bill Medicaid, Healthplex or NYState of Health Insurance and a waiver must be signed by patient that you cannot submit a claim for services rendered in our office.
• As a courtesy to you, we will bill your insurance company for services rendered.
• I understand **Lakeville Perio Implant & Dental Surgery** will reimburse me for any overpayments made.
• I understand I have the option to go to a provider who is in network with my insurance.
• Some procedures or treatments may not be covered by your insurance plan. Patients are responsible for the payment of all services rendered in this office, with or without insurance.
• Any remaining balance left after the insurance has paid their portion is the responsibility of the patient or their guardian if the patient is a minor.
• Copay and deductibles are due at time of service.
• I am responsible for providing a copy of my current insurance card to Dr. Ciornei's office. If my current insurance is incorrect, it is my responsibility to provide that information the day of service. If I fail to provide my insurance information on the day service, it may delay any payments to be made.
• I understand that I must **PAY IN FULL** the same day that services are rendered. **INITIAL HERE**_____
• I am responsible for **PAYMENT IN FULL** for any outstanding balance because of any denied, non-covered services from insurance carriers. **INITIAL HERE**_____

I acknowledge that I am fully responsible for payment for all treatment I receive in this office.
I understand my insurance carrier may deny part of, or not cover, my claim for these services.
I understand that providing Dr. Ciornei with my insurance information is my responsibility.
I understand that my insurance is a contract between myself, and my insurance carrier and that **LAKEVILLE PERIO & IMPLANT DENTAL SURGERY** has no part in this contract.
I understand the terms of this form and accept full financial responsibility with or without the use of dental insurance. **INITIAL HERE** _____
• **By my signature below, I hereby agree to and authorize assignment of benefit directly to the office.**

_____

Patient or Guardian (if under 18yrs.) Signature Date:

Dr. Gabriela Ciornei D.D.S
3517 Thomas Drive Suite 12
Lakeville, NY 14480
(585)346-7408
Lakevilleperio14480@gmail.com

PATIENT HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my care).
Obtaining payment from third party payers (e.g, my insurance company).
The day-to-day healthcare operations of your practice.
911 Emergency calls and or treatment

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these restrictions. However, if you agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

RELEASE OF MEDICAL INFORMATION CONSENT FORM

It is OK to leave messages on voice mail of phone # given? YES ☐ No ☐

If requested, you may designate the below individuals with whom we may discuss your protected health information.

I, _____ give Lakeville Perio and/or colleagues permission to discuss my protected health information with the following person/s that directly relates to that person's involvement in my health care. :

Name/Names:_____ _____

_____ _____
Signature of patient or legal representative **Date**

_____ _____
Print patient name or legal representative **Relationship to patient**

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above. I understand that I may rescind or modify the release of medical information consent at any time. This change must be made in writing to Lakeville Perio.

Lakeville Perio & Implant Dental Surgery

Dr. Gabriela Ciornei

***PLEASE FILL OUT PATIENT INFORMATION**

Date: _____

Name: _____

DOB: _____ **Phone:** _____

Address: _____ **City, State, Zip:** _____

Pharmacy: _____

OFFICE USE ONLY

Scheduled Date: _____

Procedure: _____

_____ **** OFFICE USE ONLY **** _____

Pre-med: Amoxicillin 500 mg #8 – 4 tabs – 1 hour prior to appointment	Refill: _____
Pre-med: Clindamycin 300 mg #2 – 2 tabs – 1 hour prior to appointment	Refill: _____
Pre-med: Clindamycin 150 mg #4 – 4 tabs – 1 hour prior to appointment	Refill: _____
Amoxicillin 500 mg #30 – 1-tab TID until finished	Refill: _____
Augmentin 875 mg-125 mg tab – #14 – take 1 tab every 12 hours	Refill: _____
Azithromycin (z-pak) – 2 tabs STAT – 1-tab daily	Refill: _____
Clindamycin 300 mg – #28 – 1 tab every 6 hours	Refill: _____
Doxycycline 100 mg #15 – 2 tabs after procedure, then 1 tab until finished	Refill: _____
Ibuprofen 600 mg – #24 – take 1 tab every 4-6 hours as need prn pain	Refill: _____
Paroex –16 oz – rinse with ½ oz BID (alcohol free)	Refill: _____
Peridex rinse - 16 oz – rinse with ½ oz BID	Refill: _____
PerioStat Doxycycline Hyclate – 20mg Take 1 pill 2x daily w/ full glass H2O on an empty stomach, 90-day supply	Refill: _____
Metronidazole 250 mg – #21 – take 1 tab every 8 hours	Refill: _____
Medrol Dose Pak – #1 – use as directed	Refill: _____
No Pre-med needed	_____
No Post Op antibiotics needed at this time, will decide at time of surgery	_____

DATE SENT: _____