

PATIENT REGISTRATION
Dr. Gabriela Ciornei D.D.S.

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 _____[illegible]

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 #:** _____

[illegible]

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

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** submit claims to Medicaid, Healthplex or NYState of Health Insurance. (initial) _____
- 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. (initial) _____
- 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.

Secondary Insurance Policy

Due to Lakeville Perio and Implant Dental Surgery being OUT OF NETWORK with ALL insurance companies. I understand that it is my responsibility to forward a copy of the primary EOB to this office in order for the secondary claim to be sent and processed. (initial) _____

Forwarding options:

Email Lakevilleperio14480@gmail.com

Address 3517 Thomas Drive Suite 12 Lakeville, NY 14480

- where you can mail a copy or stop by and we will make a copy for you

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.

- **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: _____ Relationship _____

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.

DO YOU WANT A COPY OF OUR PRIVACY PRACTICES YES NO

Lakeville Perio & Implant Dental Surgery
Dr. Gabriela Ciornei

PLEASE FILL OUT PATIENT INFORMATION

Date: _____ **Name** _____ **DOB:** _____
Address: _____ **City, State, Zip:** _____
Phone: _____ **Pharmacy:** _____
Allergies: _____

**** OFFICE USE ONLY ****

Scheduled Date: _____ **Procedure:** _____

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 3 x a day x 10 days	Refill: _____
Amoxicillin 500mg #21- 1 tab 3 x a day x 7 days	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: _____
Cephalexin 500mg- 28 tabs- 1 every 6 hours for 7 days	Refill: _____
Doxycycline 100 mg #15 – 2 tabs after procedure, then 1 tab until finished	Refill: _____
Diflucan	Refill: _____
Ibuprofen 600 mg – #24 – take 1 tab every 4-6 hours PRN pain	Refill: _____
Nystatin Medicated Mouth Rinse (Thrush)	Refill: _____
Paroex –16 oz – rinse with ½ oz BID (alcohol free)	Given at Office
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: _____
Lorazepam morning of and bring the extra with you	
Lorazepam night before and 30 minutes prior to appointment	
No Pre-med needed	_____
No Post Op antibiotics needed at this time, will decide at time of surgery	_____

DATE SENT: _____