Welcome

Dr. Isabelle Brunetti-Pai

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to contact us.

Patient Information Date: _____

Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Circle One: Minor Single Married Widow

Spouse or Parent's Name: _____

Person to contact in case of emergency: _____ Phone# _____

Patient's or Parent's Employer: _____ Work Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

PRIMARY DENTIST: _____

Insurance Information

Primary Insurance Company _____ Group# _____

Name of Insured: _____ Birth Date: _____

ID or Social Security No: _____ Relation to patient: _____

Employer: _____

Secondary Insurance Company _____ Group# _____

Name of Insured: _____ Birth Date: _____

ID or Social Security No: _____ Relation to patient: _____

Employer: _____

TURN PAGE OVER TO COMPLETE MEDICAL HISTORY

Health History

Physicians Name_____ **Date of last visit**_____

Have you ever had the following? Please circle those that apply:

AIDS	**Epilepsy**	**Psychiatric Care**
Anemia	**Fainting or Dizziness**	**Radiation Treatment**
Arthritis	**Glaucoma**	**Respiratory Disease**
Artificial Heart Valves	**Headaches**	**Rheumatic Fever**
Artificial Joints	**Heart Murmur**	**Scarlet Fever**
Asthma	**Heart Problems**	**Shortness of Breath**
Back Problems	**Hepatitis Type_____**	**Sinus Trouble**
Blood Disease	**Herpes**	**Skin Rash**
Cancer	**High Blood Pressure**	**Special Diet**
Chemical Dependency	**HIV Positive**	**Stroke**
Chemotherapy	**Jaundice**	**Swelling of feet**
Circulatory Problems	**Kidney Disease**	**Swollen Neck Glands**
Congenial Heart Lesions	**Liver Disease**	**Thyroid Problem**
Contact Lens	**Low Blood Pressure**	**Tonsillitis**
Cortisone Treatment	**Mitral Valve Prolapse**	**Tuberculosis**
Cough, persistent or bloody?	**Nervous Problems**	**Tumor**
Diabetes	**Pacemaker**	**Ulcer**
Emphysema	Pregnant	Venereal Disease

MEDICATIONS

List all medications you are taking:

1._____ 3._____

2. _____ 4._____

PHARMACY:_____

ALLERGIES

Aspirin	Yes	No	Local Anesthetic	Yes	No
Barbiturates	Yes	No	Penicillin	Yes	No
Codeine	Yes	No	Sulfa	Yes	No
Iodine	Yes	No	Other	Yes	No
Latex	Yes	No	List:_____		

AUTHORIZATION AND RELEASE

I read and answered the above questions to the best of my knowledge. I authorize the Doctor to release all necessary information to secure the payments of benefits. 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. I allow the dentist to communicate with other physicians, pharmacy and other allied Health professionals on my behalf and will allow dentistry to be performed once treatment is explained.

Signature: _____ Date:_____

ENDODONTIC CONSENT AND TREATMENT FORM

We would like to welcome you to our office. It is important that you be informed about various procedures involved in endodontic care. Informed consent is necessary before starting your treatment. Please take a moment to carefully read this form.

REASON FOR TREATMENT: Endodontic (root canal) therapy is accomplished in an effort to save a tooth which otherwise would require extraction. Treatment is done by standard root canal therapy, or when necessary, endodontic surgery.

OTHER TREATMENT CHOICES: These include no treatment at all, waiting for more definitive symptoms to develop, and tooth extraction. The risks involved in these choices may include pain, infection, swelling, loss of teeth, and spread of infection to other areas.

RISKS SPECIFIC TO ENDODONTIC THERAPY: Those risks include the possibility of instruments broken within the root canals, perforation/s (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, crowns, fracture of porcelain, loss of tooth structure in obtaining access to the canals, and cracked teeth. During treatment complications may be discovered which may make treatment impossible, or which may require surgery. These complications may include: blocked canals due to previous fillings or prior root canal treatment, natural calcification/s, broken instruments, curved roots, periodontal disease, splits or fractures of the teeth.

OTHER RISKS OF TREATMENT: Include (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, gums, cheeks and teeth, which is transient but on rare occasions may be permanent, reaction to injections, changes in occlusion (bite), jaw muscle cramps and spasms, Temporomandibular joint (TMJ) difficulty, loosening of teeth, referred pain to the ear, neck and head, nausea, vomiting, allergic reaction, delayed healing, sinus perforation and treatment failure.

MEDICATIONS: Prescribed medications may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from the effects.

CONSENT: I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures deemed advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office I shall return to my regular/referring dentist for a permanent restoration of the tooth involved.

I understand that root canal treatment is an attempt to save a tooth, which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth, which has had root canal therapy, may require retreatment, surgery or even extraction.

_____ _____ **Tooth#**

Date **Signature of Patient or Legal Guardian**

Date _____ **Signature of Witness** _____

Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

OFFICE POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being a success. Please understand that payment of your bill is considered part of your treatment. The following is our office and financial policy which you are required to sign:

**All patients must complete our information and insurance forms prior to seeing the doctor.
**Full payment is expected at the time of service unless other arrangements have been mutually agreed upon.
**We charge a $75.00 missed appointment fee if you do not give us a 24-hour notice when canceling or rescheduling your appointment.
**Any unpaid balance will be sent to collections after 90 days. Any and all fees incurred with the collection agency will be your responsibility.

INSURANCE: We expect full payment at the time of treatment. However, if you have dental insurance, we will contact your insurance carrier to determine the type of policy you have. The insurance form must be signed assigning benefits to Dr. Brunetti-Pai. We accept benefits as partial payment, the remaining balance must be paid PRIOR to the completion of treatment. Your insurance carrier will be charged for an exam, pre and post x-rays and the endo isolation.

PLEASE NOTE: Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. You are responsible for any balances due if there is a problem after submitting your dental claim.

After root canal treatment is complete, it is your responsibility to contact your dentist within 2 weeks to have the final restoration work done or your crown permanently cemented. Please be aware of the possibility when the doctor is drilling through an existing crown, there is a chance the crown can fracture. If this happens, you may need to have a new crown fabricated with your general dentist. We will not be responsible for any costs incurred. If you are still experiencing discomfort after 2 weeks, please contact our office. Finally, we will appoint you two check-up appointments during the first year following treatment at no cost to you.

SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this "Notice of Privacy Practices Acknowledgement", but was unable to do so as documented below:

Date:_____ **Initials:**_____ **Reason:**_____

Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐ M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____ Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____ Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
49. NPI
50. License Number
51. SSN or TIN
52. Phone Number ( ) -
52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____ Signed (Treating Dentist) Date

54. NPI
55. License Number
56. Address, City, State, Zip Code
56a. Provider Specialty Code
57. Phone Number ( ) -
58. Additional Provider ID