WELCOME TO OUR OFFICE

Francis A Bertolini, DDS

PERSONAL INFORMATION (Please Print Legibly)

Last Name: _____ First Name: _____MI: _____

I prefer to be called:_____ DOB:_____SS #: _____

Telephone - Home:_____Cell:_____Work:_____

Address: _____City: _____ State: ____ Zip: _____

Email:_____ Marital Status: S M D W

Occupation: _____ How did you hear about our office?_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship:_____

Birth Date:_____ SS#:_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone - Home:_____Cell:_____Work:_____

PRIMARY DENTAL INSURANCE

Name of Subscriber_____Subscriber ID_____ Grp. No._____

Name of Insurance Co. _____ Ph #_____

Address_____ City_____State_____ Zip_____

Policy Holder's Employer_____

SECONDARY DENTAL INSURANCE

Name of Subscriber_____Subscriber ID_____ Grp. No._____

Name of Insurance Co. _____ Ph #_____

Address_____ City_____State_____ Zip_____

Policy Holders Employer_____

Assignment of Benefits: I authorize Dr. Bertolini to furnish my insurance company with all the information to process my dental claims. I authorize the above named insurance company to pay all benefits due me directly to Dr. Bertolini. I understand I am responsible for charges not covered by this assignment. ***Also see Financial Policy attached.***

SIGNATURE:_____DATE:_____

Signature/ Guardian (if under 18 years old)

Francis A Bertolini, DDS

MEDICAL HISTORY **(Please Print Legibly)**

1. Full Name: _____ Age:_____ DOB:____/____/____
2. Emergency Contact Name:_____ Phone:_____
3. Primary Carel Physician:_____ Phone: _____
4. Date of last medical check up?_____
5. Are you under a physician's care now? Y / N If yes, please explain: _____

_____

6. Do you have any major health problems? Y / N If yes, please explain:_____

_____

7. Have you had a serious illness or injury in the last 5 years? Y / N
If yes, please explain: _____
8. Please list any medication or pills that you are now taking:

Medication	Dosage	Frequency Taken	Reason for Taking

9. Are you allergic or have you reacted adversely to any of the following:

Y / N Penicillin	Y / N Aspirin	Y / N Valium	Y / N Ibuprofen
Y / N Clindamycin	Y / N Keflex	Y / N Latex	Y / N Demerol
Y / N Amoxicillin	Y / N Tetracycline	Y / N Codeine	Y / N Sulfa
Y / N Erythromycin	Y / N Darvocet	Y / N Fluoride	Y / N Others

10. Have you ever had an unusual reaction/allergic to a local anesthetic (i.e. novocaine)? Y / N If yes, explain

_____

11. Has your physician or another dentist ever recommended the use of a premed antibiotic before dental appointments? Y / N If yes, explain _____
12. Have you ever had a dependency on alcohol or drugs? Y / N _____
13. Do you smoke or use other forms of tobacco? Y / N _____
14. Do you use recreational drugs? Y / N _____
Note: The use of recreational drugs combined with normal dental procedures can result in death.
15. Do you exercise regularly? Y / N _____
16. Do you lead a high-stress lifestyle? Y / N _____

FOR WOMEN: (1-4)

1. Is there any chance that you are pregnant? Y / N
2. Are you taking birth control pills? Y/N
3. Are you in, or have you been through menopause? Y/N
4. Have you had a hysterectomy? Y/N

For All Patients:

Y / N heart failure
Y/ N heart disease
Y / N heart attack
Y / N angina (chest pain)
Y / N heart surgery

Y / N pacemaker
Y / N mitral valve prolapse
Y / N heart murmur
Y / N congenital heart lesions
Y / N Rheumatic Fever
Y / N high blood pressure

Y / N stroke or aneurysm
Y / N sudden loss of vision
Y / N palpitations
Y / N heart fluttering
Y / N swollen ankles
Y / N congestive heart disease

Y / N shortness of breath
Y / N sleep in upright
Y / N Scarlet Fever
Y / N Rheumatic heart
Y/ N AFIB

Y / N blood disorder
Y / N Hemophilia
Y / N Anemia

Y / N Leukemia
Y / N Sickle Cell Anemia
Y / N prolonged bleeding

Y / N frequent nose bleeds
Y / N bruise easily
Y / N blood test with unusual result

Y / N blood transfusion

Y / N Asthma
Y / N wheezing
Y / N shortness of breath

Y / N Tuberculosis
Y / N Pneumonia
Y / N Emphysema

Y / N chronic cough
Y / N cough up blood
Y / N collapsed lung

Y / N hay fever
Y / N acid reflux

Y / N artificial joint

Y / N organ transplant

Y / N Epilepsy
Y / N seizures
Y / N dizzy spells

Y / N paralysis
Y / N neuralgia
Y / N frequent headaches

Y / N migraine headaches
Y / N head injury
Y / N hearing problems

Y / N impaired vision

Y / N clinical depression

Y / N anxiety

Y / N psychiatric treatment

Y / N hives

Y / N ulcers
Y / N colitis
Y / N liver disease

Y / N cirrhosis
Y / N Hepatitis A, B, C
Y / N Jaundice

Y / N chronic diarrhea
Y / N blood in urine/stools
Y / N parasites

Y / N kidney disease

Y / N AIDS

Y / N HIV Positive

Y / N venereal disease

Y / N Herpes

Y / N Diabetes
Y / N abnormal thirst
Y / N sores that don't heal
Y / N swollen glands
Y / N Hodgkin's Disease

Y / N adrenal problems
Y / N thyroid problems
Y / N Multiple Sclerosis
Y / N Fibromyalgia
Y / N sleep disorder

Y / N cancer
Y / N tumors
Y / N chemotherapy
Y / N radiation treatment
Y / N arthritis

Y / N Lupus
Y / N back/neck problems
Y / N skin disease
Y / N recent weight change
Y / N restricted diet

Do you have any disease, conditions, allergies, or anything else not listed above. If so, please describe:

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or if my medications change, I will inform the doctor or hygienist at my next appointment.

_____ Date

_____ Signature of Patient, Parent, or Guardian

UPDATES:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

DENTAL HISTORY

You deserve to achieve the level of health and comfort you desire. We need all this information to do so predictably. We know we are asking for a lot of information and we appreciate your time in completing these very important forms. We prefer to treat friends and the best way to do this is to get to know you and your needs very well.

Have you had a bad experience in the dental office? ____Yes ____No

Are you in any discomfort at this time? ____Yes ____No

Have you lost any teeth? ____Yes ____No

Why?_____

Any complications with extractions? ____Yes ____No

What?_____

Have you had teeth replaced by:

a fixed bridge / a removable partial / a denture? (circle those applicable)

Are your teeth sensitive to heat? ____Yes ____No

to cold? ____Yes ____No

to sweets? ____Yes ____No

to sour? ____Yes ____No

Do you have dry mouth? ____Yes ____No

Are you drinking fluids frequently? ____Yes ____No

How many glasses a day?_____

How long do you use a toothbrush before replacing it?_____

Do you floss? How often?_____ ____Yes ____No

Do you use a between the teeth stimulator or water jet? ____Yes ____No

Do your gums bleed? ____Yes ____No

When?_____

Do you eat between meals? ____Yes ____No

Do you brush after snacks? ____Yes ____No

Have you had your teeth straightened? ____Yes ____No

When?_____

How often do you brush your teeth?_____ When?_____How?_____

Does food wedge between your teeth? ____Yes ____No

Where?_____

Do you grind or clench your teeth? ____Yes ____No

When?_____

Continued on the reverse

Have you ever had gum (periodontal) treatments? ____Yes ____No

When?_____

Do you feel you have bad breath at times? ____Yes ____No

Unpleasant taste in your mouth? ____Yes ____No

Any pain around your ears? ____Yes ____No

Do your ears feel blocked? ____Yes ____No

Do you snore?

Do you have a nasal obstruction? ____Yes ____No

Do you hear popping, clicking, or snapping noises when you chew? ____Yes ____No

Are you aware of any swelling or lump in your mouth? ____Yes ____No

How long has it been since you have been to the dentist?_____

What was done then? _____

Did you have x-rays? ____Yes ____No

How often did you visit a dentist before then?_____

Many patients consult with us for another opinion:

Have you seen another dentist for your current dental needs? ____Yes ____No

If yes, please explain. _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 - would never doze
1 - slight chance of dozing
2 - moderate chance of dozing
3 - high chance of dozing

CHANCE OF DOSING	SITUATION
_____	Sitting and reading
_____	Watching TV
_____	Sitting, inactive in a public place such as a theater or a meeting
_____	As a passenger in a car for an hour without a break
_____	Lying down to rest in the afternoon, when circumstances permit
_____	Sitting and talking to someone
_____	Sitting quietly after lunch without alcohol
_____	In a car, while stopped for a few minutes in traffic
_____	**Total score - add all responses**

DON'T WAIT UNTIL IT HURTS...

Periodontal disease is painless. It affects 87% of the population and often victims are unaware. There are warning signs which the American Dental Association and our staff would like you to be aware of.

Do your gums bleed when you brush your teeth or toothpick between them?	____Yes ____No
Are your gums red, swollen or tender?	____Yes ____No
Are your gums pulling away from your teeth?	____Yes ____No
Do you see pus between your teeth and your gums when gums are pressed?	____Yes ____No
Are your permanent teeth loose or separating?	____Yes ____No
Is there any change in the way your teeth fit together when you bite?	____Yes ____No
Is there any change in the fit if your partial dentures?	____Yes ____No

If the answer is yes to any of these questions, you owe it to yourself to bring it to the attention of your dentist or hygienist. Act now and keep your teeth for a lifetime!

Continued on the reverse

SMILE EVALUATION

A few questions to help you obtain the smile you've always wanted!

Are your teeth Chipped / Protruding / Hidden? ____Yes___No

Are your teeth all in alignment (straight)? ____Yes ____No

If not, explain._____

Do you have spaces that you don't like? ____Yes ____No

If yes, explain._____

Do you like the color of your teeth? ____Yes ____No

If not, explain._____

If you could safely whiten your teeth, would you be interested? ____Yes ____No

Do you like the shape of your teeth? ____Yes ____No

If not, explain._____

Are there old fillings or dental work that show when you smile or you are unhappy with the look of?

____Yes ____No If yes, explain._____

Do you clench or grind your teeth? ____Yes ____No If yes, explain._____

What would you like to change the most about the appearance of your teeth?

_____

_____

_____

_____

WE WELCOME ALL PATIENTS

Our goal is to help you take care of your teeth, smile, and mouth at the level that is right for you.

In our practice, we believe that the level of care you want is your choice. We will help you thoroughly understand your dental choices so you can make the best possible decision. Your first choice is how you would like us to work with you. Please consider the following guidelines for care so that we can best meet your goals:

☐ **LEVEL 1: URGENT CARE**

Patients at this level choose treatment only when they experience a crisis such as pain, swelling or bleeding that requires immediate treatment. Urgent care patients are generally not focused on taking steps to ensure future urgencies do not occur. They come in when they know they have a major problem to deal with and the condition has developed to a point of urgency in order to control pain or save the tooth.

☐ **LEVEL 2: REMEDIAL CARE**

Patients at this level choose treatment for obvious problems such as broken or cracked teeth. cavities, sensitivity, discomfort or concerns that are creating issues in the mouth right now. Remedial care patients are usually not focused on taking steps to prevent new concerns or improve their health over time. They only want to deal with concerns that have already developed into conditions that require treatment to remove existing disease or repair the teeth back to the most basic level of health.

☐ **LEVEL 3: PROACTIVE CARE**

Patients at this level seek treatment for existing concerns just like remedial care patients, but they are also concerned about conditions that may create problems in the near future. These patients generally want to maintain the health of each tooth at a basic level so they also do what they can to prevent new concerns from developing. When treatment is recommended, proactive care patients usually prioritize their treatment to manage their costs but still take care of things soon enough so that known concerns are less likely to develop into major problems.

☐ **LEVEL 4: COMPLETE DENTISTRY**

Complete dentistry patients are concerned about the current conditions in their mouth, the causes of dental disease and their long-term health. They want to know their full treatment options so they can become and remain as healthy as they can be, thereby minimizing their long-term dental costs. These patients often choose a step-by-step master plan focused on restoring their health combined with prevention and regular care to achieve steady long-term dental health and an improved appearance to their smile over time.

☐ **LEVEL 5: OPTIMAL DENTISTRY**

Just like complete dentistry patients, patients at this level are focused on long-term dental health and disease prevention, but they also want their teeth and smile to look great. Patients at this level are interested in treatment options to correct all dental concerns for lifelong optimal function and appearance. For some of these patients, enhancing their appearance with a beautiful new smile Is very important.

It is not uncommon for people to begin at one level and progress to higher levels when they are ready. We're here to help you discover what is right for you so your teeth, smile, and mouth remain as healthy as they can be for life based on your goals.

Financial Policy

FULL PAYMENT IS DUE AT TIME OF SERVICE

Our office gladly accepts Visa, MasterCard, Discover, cash, personal checks, and CareCredit.
If you would like to apply for CareCredit financing, please consult our front office staff.

For Patients With Insurance

As a courtesy to our patients with insurance, we will file your dental claims for services rendered. Any amount not paid by insurance is your responsibility. We will be happy to file a pre-determination to the insurance company so we can get a more accurate estimate of what they should pay, but it is still not a guarantee of their payment. You are responsible for paying any deductible and copayment at the time of service. Once we receive payment from the insurance company, you will be required to pay any balance due upon receipt of your statement. The balance due for services provided is the patient's responsibility, even if the insurance company pays nothing. If you have overpaid your portion, you may request a refund or use the credit for additional work that may be needed.

Delinquent Accounts

If in 30 days your balance remains unpaid, we reserve the right to add 18% annual interest to the unpaid balance.
We reserve and will exercise the right to report any account 90 days past due to a Collection Agency. All expenses incurred as a result will be the patient's responsibility, as permitted by law.

Cancellations & Missed Appointments

Appointments are valuable blocks of time and when an appointment is broken or canceled with short notice, we are often prevented from filling that time and helping other patients. Please give at least ***24 business hours notice*** when you will not be able to make your scheduled appointment. This will allow us time to help other patients and helps keep costs down. We reserve the right to charge for all broken or canceled appointments with less than the required 24 business hour notification. Additionally, if you are more than 15 minutes late for an appointment, you may be asked to reschedule.

All Patients Please Sign

By signing below, I certify that I have read, understand, and agree to this policy.

Patient Signature _____ Today's Date_____

Appendix 2.3.2

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

Francis A. Bertolini, DDS FAGD

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____Email:_____

Please check which phone # you'd prefer to be reached:

☐ Home #:(____)_____ ☐ May we leave you a message?

☐ Cell #: (____)_____ ☐ May we leave you a message? ☐ May we text appointment reminders?

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other - Please Specify:

Photographic Release

I consent and agree to the use, reproduction or otherwise published photograph of me in any publication or lecture presentation of this doctor. Dr. Bertolini or any other person authorized by him has the right to use such images in any advertising and promotion of such publication and the dispositions of all rights thereto. Your name will not be used with your image.

_____ (initials)

I further agree I will not assert any claims against any party whatsoever based on the usage of the images or make any claim to the use of the images defaming me or constitutes an infringement on my right to privacy or any other right I may enjoy.

_____ (initials)

To our No Cavity Club Winners: We want to ***celebrate*** our young patients' cavity free smiles, which is why we photograph Dr. Bertolini with our winners & with your permission we post on Facebook and Instagram.

*We respect your privacy, our office will **never** post your child's first or last name.*

Thank you!

The Francis A. Bertolini, DDS Dental Team

follow us **@NorthCantonSmiles**

_____

Patient Name

_____ _____

Signature/ Guardian (if under 18 years old) Date