FAYE E. LICATA, D.M.D., F.A.G.D., P.C.
111 HILLTOWN VILLAGE CENTER #200
CHESTERFIELD, MO 63017
(636)532-2101

PATIENT INFORMATION
Name_____Date of Birth_____
Address_____
City, State, Zip_____
S. S. #_____-____-_____Home Phone_____Bus. Phone_____
Cellular Phone_____ E-Mail Address_____
Patient Occupation_____Employer_____
Years with firm_____

RESPONSIBLE PARTY INFORMATION
Name_____ Date of Birth_____
Address_____
City, State, ZIP_____
S.S. #_____-_____-_____Home Phone_____Bus. Phone_____
Cellular Phone_____ E-Mail Address_____
Responsible Party
Occupation_____Employer_____
Years with firm_____

INSURANCE INFORMATION
Employer's Name and Address_____
_____
_____
Employer's Phone Number_____Group Number_____
Insurance Company Name and Address_____
_____
_____
Insurance Company Phone Number_____

MISCELLANEOUS
Whom may we thank for referring you to our office?_____

If you are completing this form for another person, what is your relationship to that person?_____

Who shall we contact in case of an emergency?_____
What is this person's phone number?_____

FAYE E. LICATA, D.M.D., F.A.G.D., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____
Please Print Name

_____
Signature

_____
Date

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)

_____

_____

_____

FAYE E. LICATA, D.M.D.
111 Hilltown Village Center, Suite 200, Chesterfield, Missouri 63017
(636) 532-2101

Date _____

Name _____ Gender: M or F Date of Birth _____

PATIENT MEDICAL HISTORY

1. Have you been a patient in a hospital or had a serious illness during the past five years? ☐ Yes ☐ No

   If yes, for what reason _____

2. Have you been under the care of a physician during the past two years? ☐ Yes ☐ No

   If yes, reason for treatment _____

3. Are you currently taking any type of medication? ☐ Yes ☐ No

   If yes, what type of medication and for what reason _____

4. Are you allergic to any drugs or medication? ☐ Yes ☐ No

   If yes, explain: _____

If you have ever had any of the following, please check:

☐ heart trouble	☐ asthma	☐ arthritis	☐ rheumatic fever
☐ congenital heart lesions	☐ cough	☐ stroke	☐ cancer
☐ heart murmur	☐ diabetes	☐ epilepsy	☐ kidney disease
☐ high blood pressure	☐ tuberculosis	☐ psychiatric treatment	☐ fainting spells
☐ anemia/blood disorder/transfusion	☐ hepatitis	☐ sinus trouble	☐ venereal disease
☐ joint surgery or replacement	☐ jaundice	☐ stomach ulcers	☐ hives or skin rash
☐ HIV	☐ latex allergy	☐ thyroid disease	

Any additional information or remarks _____

5. Approximate date of last physical examination _____

6. Personal Physician _____ Phone _____

   Address _____

7. (Women) Are you pregnant? ☐ Yes ☐ No _____

PATIENT DENTAL HISTORY

1. Have you had any serious trouble associated with any previous dental treatment? _____
2. What is your chief dental concern? _____
3. Have you ever had prolonged bleeding from an extraction? _____
4. Are you uncomfortable or nervous to be at the dentist office? _____
5. How often do you brush your teeth? _____
6. How often do you floss your teeth? _____

Check any of the following concerns, past or present ...

☐ Tooth sensitivity to hot or cold	☐ Dry mouth	☐ Cavities	☐ Gum disease
☐ Constant sore or hoarse throat	☐ Toothaches	☐ Tartar build-up	☐ Crowded teeth
☐ Red, swollen or tender gums	☐ Shifting teeth	☐ Bad breath	☐ Loose teeth
☐ Improving the appearance of your teeth	☐ Bleeding gums when brushing or flossing	☐ A change in the way your teeth bite together	☐ TMJ history ☐ Ortho treatment

Cancellation and Broken Appointment Policy

We understand that illness, emergencies, flat tires, and bad weather do occur. However, we ask our patients to give us a 72 hour notice if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy and Fees:

Cancellation and rescheduling of an appointment **with 72 hours** or more notification-**no charge.**

Cancellation or rescheduling of an appointment **less than 72 hours and up to 24 hours** may or may not be considered a broken appointment; it will be at our discretion.

Failure to give 24 hours advance notice:

- We allow for one (1) broken appointment within a 12 month period.
- A fee of $75 is charged for a missed hygiene appointment.
- A fee of $100 is charged for a doctor's appointment scheduled for an hour or less. After that, an additional fee of $75 per half hour is added.

A broken appointment is when you:

- **Cancel** or **reschedule** an appointment with **less than 72 hours notice.**
- **Do not show up** for the scheduled appointment.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of the care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to contact us at Licata Dental.

I have read and understand the above mentioned policy.

_____

Patient signature (Parent or Guardian if minor) Date