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

111 HILLTOWN VILLAGE CENTER #200 CHESTERFIELD, MO 63017
(636)532-2101 Office@LicataDental.com

Date_____

Patient Name_____ Date of Birth_____

MEDICAL HISTORY

Have you been a patient in a hospital or had a serious illness in the last 5 years? Yes / No
If yes, why? _____

Have you been under the care of a physician in the last 2 years? Yes / No
If yes, why?_____
Are you currently taking any medications? Yes / No
If yes, please list name and reason why:_____
Do you have allergies to medications, drugs, anesthetics, metals, latex, or acrylic, or other? Yes / No
If yes, please list and explain:_____
Approximate date of last physical examination_____
Personal Physician's Name_____ Phone Number_____
Address_____

Have you ever taken Fosamax, Boniva, Actonel, or any medicine with bisphosphonate? Yes/No
Have you ever taken Phen-Fen or Redux? Yes/No
(Women) Are you pregnant? Yes/No

Please circle any history with the following:

AIDS/HIV	Diabetes	High Cholesterol	Recent Weight Loss	Any illness not listed here?
Alzheimer's	Epilepsy	Hives or Rash	Renal Dialysis	
Anaphylaxis	Fainting/Dizzy	Hypoglycemia	Rheumatic Fever	
Angina	Frequent Cough	Irregular Heartbeat	Rheumatism	
Arthritis	Frequent Headache	Jaundice	Scarlet Fever	
Artificial Joint	Genital Herpes	Kidney Problems	Shingles	
Asthma	Glaucoma	Leukemia	Sickle Cell Disease	
Bleeding Issues	Hay Fever	Liver Disease	Seizures	
Blood Disease	Heart Attack	Low Blood Pressure	Sinus Trouble	
Breathing Problems	Heart Pacemaker	Lung Disease	Stomach or Intestinal Disease	
Cancer	Heart Trouble	Mitral Valve Prolapse	Stroke	
Chemotherapy	Hemophilia	Osteoporosis	Thyroid Disease	
Chest Pains	Hepatitis A, BH, or C	Parathyroid Disease	Tonsillitis	
Congenital Heart Issues	Herpes	Psychiatric Care	Tuberculosis	
Convulsions	High Blood Pressure	Radiation Treatments	Tumors	

If none of the above are circled, I acknowledge I have no existing problems with any health issues listed above. I acknowledge I answered these questions accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.

Patient Signature (or Parent/Guardian if signing for minor) Date

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Date_____

Patient Name_____ Date of Birth_____

DENTAL HISTORY

What is your chief dental concern at this time?_____

Have you ever had serious problems associated with previous dental treatment? Yes / No
If yes, what?_____
Have you ever had prolonged bleeding with any dental procedure or extraction? Yes / No
Are you uncomfortable to be at the dentist? Yes / No
If yes, why?_____
How often do you brush your teeth?_____
How often do you floss?_____
Do you use tobacco products? Yes / No If yes, how often?_____
Do you consume alcohol? Yes / No If yes, how often?_____
Have you ever had a serious injury to your head, neck, or teeth? Yes / No
If yes, please explain_____
Do you grind your teeth? Yes / No
Do you have frequent headaches in your temples, jaws, or neck? Yes / No
If yes, please explain_____
Any history of pain in your jaw joints (TMJ's)? Yes / No
Have you had your 3rd molars removed? Yes / No If yes, when?_____
Have you worn braces? Yes / No If yes, when?_____
Would you like to improve your smile in any way? Yes / No
If yes, please explain _____

Please circle any history or concern with your oral health:

Cold sensitivity	Deep red color of gums	Frequent Cold Sores	Changes in your bite
Heat sensitivity	Bleeding gums	Fever blisters	Crowded teeth
Chewing Sensitivity	Sore gums	Toothaches	Floss snags or shreds
Sensitivity at rest	Loose teeth	Shifting teeth	Food traps
Chronic sore throat	Tartar Builds Fast	Cavities	TMJ Clicks or Pops
Dry mouth	Swollen Gums	Bad Breath	TMJ Pain

If none of the above are circled, I acknowledge I have no existing problems with any health issues listed above. I acknowledge I answered these questions accurately. I understand that providing incorrect information can be damaging to my oral health. It is my responsibility to inform the dental office of any changes in my dental status.

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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 Employer_____

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 Employer_____

DENTAL INSURANCE INFORMATION

Employer's Name and Address_____
_____
_____
Employer's Phone Number_____
Group Number_____ Member ID Number_____
Dental Insurance Company Name and Address_____
_____
_____
Dental Insurance Company Phone Number _____
Are you aware if this is termed as a "Reimbursement Policy"?_____

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?_____

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Payment Policy

Payment is due at the time treatment is rendered.

If needed, financial arrangements can be discussed at the beginning before any treatment is started. Payment terms must be mutually agreeable between the patient and Licata Dental and made in advance before treatment is started. Otherwise, payment is due in full at the end of each treatment phase.

Licata Dental will make every best effort to inform you of our fees before treatment begins, but unforeseeable changes can and do occur during treatment that could alter the treatment plan, which in turn can alter the fees. If this happens, Dr. Licata will discuss the changes in treatment at the time they happen. Dr. Licata will then explain how any changes may alter the cost of the original proposed treatment. Decisions can then be made as to the best way to proceed.

There will be a $40 charge for any check returned by our bank for any reason.

Insurance:

Insurance is a contract between a patient and the insurance company.

Licata Dental will aid in submitting an insurance claim form but Licata Dental has no control over what procedures are covered, or in what monetary amount.

No insurance company attempts to cover all dental costs. There is generally a limit to the amount an insurance company will pay. It is the patient's responsibility to pay any deductible amount, co-insurance, or other balance not paid by your insurance company. This payment is due when the last open claim filed has cleared.

Licata Dental will always help with filing insurance claims. However, after 90 days if the insurance company has not reimbursed Licata Dental for services rendered, the patient is responsible for payment to Licata Dental in full for the services. It will then become the patient's responsibility to pursue follow up with their insurance company regarding payment for a submitted claim.

In the event your account requires collection services to obtain payment for charges, I understand that I am fully responsible for any collection fees. I have read and understand the above policy.

Patient Signature (or Parent/Guardian if signing for minor) Date

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Cancellation and Broken Appointment Policy

We understand that emergencies, illness, and bad weather can occur. However, we ask for a 72-hour notice if an appointment cannot be kept so that we may offer our scheduled time to others who are waiting for our help.

POLICY AND FEES:

A Cancellation or Reschedule with 72 hours or more notification—No Charge.

A Cancellation or Reschedule with 24-72 hours notification—May or May Not Charge—Our Discretion.

Failure to Give 24 Hour Advance Notice:

A fee of $95 is charged for a missed hygiene appointment.

A fee of $125 is charged for Dr's appointment of an hour or less. For each additional 30-minute block of time scheduled with Dr, a fee of $75 will be added.

A Broken Appointment:

Occurs if there is a cancellation or reschedule with less than 72 hour notice.

Occurs if there is failure to arrive at our office at the time of your scheduled appointment.

We appreciate your understanding regarding our appointment policy. If you have any questions or concerns regarding our broken appointment policy, please contact us at Licata Dental.

I have read and understand the above policy.

Patient Signature (or Parent/Guardian if signing for minor) Date

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received and reviewed a copy of this office's Notice of Privacy Practices. (A copy is available on LicataDental.com or available in office by request.)

Patient Printed Name

Patient Signature (or Parent/Guardian if signing for minor) Date

HIPAA RIGHT OF ACCESS

I give permission for Licata Dental to discuss my protected health information regarding dental and financial records with the following people listed below:

Names:	Relationship
_____	_____
_____	_____

Patient Printed Name

Patient Signature (or Parent/Guardian if signing for minor) Date