FAMILY & COSMETIC DENTISTRY

REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Patient's Last Name:	First:	MI:	Marital Status: Single ☐ Mar. ☐ Div. ☐ Sep. ☐ Wid. ☐	
			Social Security #:	Birth Date:
Street Address:			Age:	Sex: ☐M ☐F
City:			State:	ZIP Code:
Cell Phone #: ( )			Home Phone #: ( )	
Preferred Method of Contact: Phone ☐ Email ☐ Text ☐			Email:	
Employer:			Employer Phone #: ( )	
How Did You Find Us? ☐ Close To Home/Work ☐ Insurance Plan ☐ Internet ☐ Mailing ☐ Family/ Friend ☐ Other				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
			( )

Is this patient covered by insurance? ☐ Yes ☐ No	Name of Primary insurance (if applicable):

Subscriber's Name:	Subscriber's S.S#:	Birth Date:	Group No.:	Policy No.:

Patient's relationship to subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Is this patient covered by a second insurance? ☐ Yes ☐ No	Name of Secondary insurance (if applicable):

2nd Subscriber's Name:	2nd Subscriber's S.S#:	Birth Date:	Group No.:	Policy No.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone # :	Cell phone #:
		( )	( )

CONSENT

I herby authorize payment directly to the dental office of John C. Melucci, D.D.S., the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office of John C. Melucci, D.D.S. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental /medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

Patient/Guardian signature	*Date*

JOHN C. MELUCCI DDS ~ 3733 Poplar Avenue ~ Castle Shannon, Pennsylvania 15234
Phone: 412 -531-6804 ~ Email: jcmeluccidds@comcast.net
Website: www.meluccidds.com

PATIENT QUESTIONNAIRE

PATIENT NAME_______________________________ **DATE**__________

What are some of your **reasons for coming** in to see Dr. Melucci?

____

What is **most important** to you **in a relationship** with your **dentist**?

____

When someone is **presenting** something new to you, do you want the **Details** ☐ or **Big Picture**☐?

On a scale of 1-10, how important is **dental health** to you? **1 2 3 4 5 6 7 8 9 10**

On a scale of 1-10, how do **you feel** about the way **your smile** looks? **1 2 3 4 5 6 7 8 9 10**

On a scale of 1-10, how **comfortable** do you feel **showing your teeth** when you smile or laugh?
1 2 3 4 5 6 7 8 9 10

Do you **smoke?** Yes☐ No☐ if yes, **how many** cigarettes per day 1 - 3☐ 4+☐

Do you **drink coffee, tea, red wine or dark colas**? Yes☐ No☐ if yes, how much 1 - 2 ☐ 2 - 3☐ 4+☐

What is **most important** to you about your teeth and gums?
☐ They Look **Attractive** ☐ They **Feel Good** ☐ You Want Others to **Compliment** Smile

If you could **change anything** about your smile what would it be? (Please check all that apply)

☐**Chipped** teeth
☐**Whiter** teeth
☐**Overlapping** teeth
☐Uneven or **crooked** teeth
☐Teeth that appear are **too large or too small**
☐**Unattractive front** caps or bridgework
☐To cover up **silver fillings** when you smile
☐To change the **size/shape** of your teeth
☐**Sensitive** teeth
☐To **look younger**
☐Remove white **spots** on your teeth
☐**Reduce pointed** eye teeth
☐Reduce **spaces** between your teeth
☐**Align** rotated teeth
☐A more **self-confident** smile

What would be your reason for not doing needed dental treatment?
☐ **Cost** ☐ **Time** ☐ **Anxiety** ☐ **Other:** _______________________________

Thank you kindly for taking the time to fill out our patient questionnaire.
Dr. Melucci & Team

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MELUCCI DDS
Family & Cosmetic Dentistry

PATIENT NAME________________________________ **DATE**__________

DENTAL HISTORY

What is the reason for your visit today?
Please explain____

Do you have a specific problem, currently in pain?
Describe____

When was your last dental examination? ________________________________

Do you think you have any of these conditions? (Please check)

- ☐ active decay
- ☐ food catch between your teeth
- ☐ you brux or grind
- ☐ sensitive to hot or cold
- ☐ do your gums ever bleed
- ☐ frequent headaches
- ☐ gum disease
- ☐ mouth odors or bad tastes
- ☐ sores or growths in your mouth
- ☐ loose teeth
- ☐ clicking, popping or discomfort in the jaw joint

Have you ever had any of the following? (Please check)
☐ bite plate/ mouth guard ☐ orthodontic treatment ☐ a serious injury to the mouth or head

Have you ever had trouble with previous dental treatment? Yes ☐ No ☐
Describe____

MEDICAL HISTORY

Are you under a physician's care now? If yes Why? ________________________________
Physician's Name & Phone #________________________________

WOMEN ONLY (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐Taking oral contraceptives

Are you CURRENTLY TAKING any of the following therapy MEDICATIONS OR TREATMENTS?
(Please check)

- ☐Beta Blockers
- ☐Prednisone
- ☐Plavix
- ☐Aspirin
- ☐Coumadin
- ☐Cortisone
- ☐Chemotherapy
- ☐Blood Transfusion
- ☐Renal Dialysis
- ☐If not listed… please provide type & dosage: ________________

____

Are you NOW OR have you EVER involved in any of the following therapy medications, treatments or surgical procedures? (Please check)

- ☐Pace Maker*
- ☐Blood Transfusion
- ☐Transplant
- ☐Artificial Joint*
- ☐Artificial Heart Valve/Stent*
- ☐Radiation (Head/Neck)
- ☐Heart Surgery (other)*
- ☐ Bisphosphonates drugs: ie: Actonel, Aredia, Bonefos, Boniva, Didronel, Fosamax/Fosamax Plus D, Skelid, Zometa,

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MEDICAL HISTORY (Continued)

Are you ALLERGIC to any Medications or Substances? (Please check)

☐Penicillin ALLERGY ☐Cephalosporin ALLERGY ☐Clindamycin ALLERGY
☐Epinephrine ALLERGY ☐Codeine ALLERGY ☐Anesthetics Sensitivity (ie: Novocain)
☐Latex ALLERGY ☐Acrylic ALLERGY ☐Skin reactions to jewelry
☐NSAIDS ALLERGY(non-steroidal anti-inflammatory drugs) ie: aspirin, Celebrex, ibuprofen, naproxen, Lodine, etc.
☐Other, Please list: ____

Do you SUFFER from any of the following RECENTLY OR REGULARLY? (Please check)

☐Heart Attack/Failure*	☐Swelling of Limbs	☐Shortness of Breath	☐Seizures
☐Bruise Easily	☐Excessive Bleeding	☐Excessive Thirst	☐Frequent Cough
☐Sinus Trouble	☐Fever Blisters	☐Hives/Rash	☐Cold Sores
☐Hypoglycemia	☐Low Blood Pressure	☐Fainting/Dizziness	☐Nervousness/Anxiety
☐Irregular Heart Beat	☐Drug Addiction	☐Herpes	☐Shingles
☐Jaundice	☐Chest Pain	☐Ulcers	☐Anemia
☐Bowel Disorder	☐Scarlet Fever	☐Venereal Disease	☐Frequent Diarrhea
☐Weight Loss (involuntary)			

Have you EVER been DIAGNOSED with and/or TREATED for any of the following DISEASES OR CONDITIONS? Please check *all* that apply.

☐Mitral Valve Prolapse*	☐Hemophilia (Bleeding)	☐Cancer
☐Endocarditis/Heart Disease*	☐Anemia	☐Tumors or Growths
☐Heart Murmur*	☐Nervousness/Anxiety	☐Parathyroid Disease
☐Angina	☐Alzheimer's Disease	☐Thyroid Disease
☐Congenital Heart Disorder*	☐Psychiatric Disorder	☐Diabetes
☐Stroke	☐Osteoporosis	☐Liver Disease
☐Blood Disease	☐Rheumatic Fever*	☐Jaundice
☐Sickle Cell Disease	☐Lung Disease	☐Kidney Disease
☐AIDS	☐Breathing Problem	☐Stomach/Intestinal Disease
☐HIV Positive	☐Tuberculosis	☐Arthritis/ Rheumatism
☐Hepatitis A (Infectious)	☐Asthma	☐Epilepsy
☐Hepatitis B or C	☐Emphysema	☐Glaucoma
☐High Blood Pressure		

Have you ever had any other serious illness not checked above? ***If yes please discuss***
____

Have you ever been asked to PREMEDICATE for a dental appointment? Yes☐ No☐
(If you have said yes to any of the starred (*) conditions above, pre-medication may be required even if you've never been asked before.

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE CORRECT. IF I HAVE ANY CHANGES IN MY HEALTH STATUS OR IF MY MEDICINES CHANGE, I SHALL INFORM THE DENTIST AND STAFF AT THE NEXT APPOINTMENT.

____
SIGNATURE: PATIENT (PARENT OR GUARDIAN) **DATE**

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Family & Cosmetic Dentistry

OUR RESTORATION POLICY

At the Family & Cosmetic Dentistry of John C. Melucci DDS you will be offered a full range of restorations and/or cosmetic procedures, as applicable to your specific case. This means that your dental insurance may only contribute a portion or nothing at all, to the total procedure fees. It is important for you to understand that if you choose to proceed with a higher restorative option you will be responsible for the difference between the full procedure fee and the amount contributed by your insurance company ***regardless of our network participation.***

Theses may include but are not limited to

- Crowns/Inlays/Onlays containing **precious metal**
- **all-ceramic** Crowns/Inlays/Onlays
- **all** implant restorations
- dental bridges containing **precious metal**
- **cosmetically designed** full or partial dentures
- **cosmetic procedures** such as veneers or whitening,
- Invisalign
- TMJ procedures & appliances

As previously stated all patients are offered every option that is appropriate for the treatment of their particular condition. There will always be a non-precious metal restoration alternative, at network fees, included in the treatment plan discussion.

Furthermore, we believe in full disclosure. We will discuss with you the cost of any and all major restorations in advance. In the case of higher or upgrade restorations, we will provide you with a written statement of estimated costs for the desired procedures. They are of course estimates based upon benefits as they are known to us at the time. They are subject to change due to alterations, cancellations, and/or individual insurance plan methodology.

We have made a *commitment* to provide you with the highest level of dental care dentistry can offer. We realize that every patient's financial situation is different. So we offer several payment options to make it possible for you to receive the restoration that you deserve. If you have any questions at all, please bring these matters to our attention promptly so we may clarify any issues ***before*** your dental treatment is initiated.

We are truly grateful that you have chosen our practice for your dental home.

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Family & Cosmetic Dentistry

RESTORATION POLICY ACKNOWLEDGEMENT

I have received the notice of the restoration policy and I have been provided an opportunity to review it. I understand that the office of John C. Melucci DDS can and will hold me fully responsible for the difference between the full procedure fee and the amount contributed by my insurance company ***regardless of network participation,*** on any non-basic procedures or any treatment procedure not covered by insurance. **I understand that I am ultimately financially responsible for all charges whether or not they are covered by insurance.**

Name____

Signature____

Date____

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OUR PAYMENT OPTIONS

We have made a commitment to provide you with the highest level of care dentistry can offer. At the same time, we realize that every patient's financial situation is different. We do request dental treatment to be **paid at the time services are rendered.** So we offer the following selection of payment options so as to fit some of the more expensive treatments within one's financial means.

Platinum Plan Our ***Full Pay Discount*** Option: This option is for large cases which may include treatment with Crowns, Onlays, Bridgework, dentures, Implants and Cosmetic procedures.

We offer a ***5%*** professional courtesy discount for dental treatments over $600.00 that are ***paid in its entirety by check or cash*** the day the service is initiated.

We offer a ***2%*** professional courtesy discount for treatments ***paid in full by credit card*** on the day treatment begins.

Gold Plan Our ***standard two-payment*** option: This plan is for major restorative treatment over $500. One-half of your fees are paid at the first appointment and the balance paid the *day* the restoration is placed.

This option works especially well for treatment in which insurance will be paying a portion. ***Note***: this may vary somewhat since some major restorative treatment can involve several appointments.

Silver Plan Our ***CareCredit Payment Plan*** Option: A wonderful way to afford more expensive dental care by way of payment plans which may allow you to spread your payments out up to 60 months. This option is for a monthly payment that allows you to reserve your standard credit cards for other things.

CareCredit will bill you directly for your treatment. **CareCredit** is a revolving line of credit approved by **CareCredit**, so when you pay down or pay off the amount, the credit is immediately available for you to use again.

We offer the following types of transactions alone, in combination with insurance benefits or with any of the above payment options above. And they may be combined to create the best combination to suit your budget and service your needs at the same time.

Check, Cash, Debit Card, VISA/MasterCard, Discover, American Express

We know you will have questions regarding your insurance coverage. *Please* bring these matters to our attention promptly so we may clarify insurance issues ***before*** your dental treatment is initiated.

Remember, we are always here to serve ***you*!**

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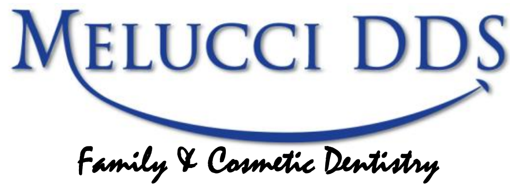

PRE-AUTHORIZED DENTAL HEALTH CARE FORM

I hereby give authorization for payment of dental insurance benefits to be made directly to **JOHN C. MELUCCI, D.D.S** for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I understand all patients are responsible for any and all non-covered services as outlined by their plan. I hereby authorize **JOHN C. MELUCCI, D.D.S** to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. **I understand that this form is valid for one year or until I notify the dental office of JOHN C. MELUCCI, D.D.S at which time this agreement will become void.**

____

SIGNATURE OF RESPONSIBLE PARTY **Date**

I authorize the dental office of JOHN C. MELUCCI, D.D.S., to keep my signature on file and to charge my VISA, MasterCard, Discover, American Express or my Debit Card account for the balance of charges not paid by my insurance.

Please Check One:

____AMERICAN EXPRESS ____MASTERCARD ____VISA ____DISCOVER ____DEBIT CARD

Patient Name____

Cardholder Name____

Cardholder Address____

City__________________________**State**____________**Zip**_____________________

Account #____

Expiration Date______________ **CVV#** ____________

Cardholder Signature________________________________ **Date**______________

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Family & Cosmetic Dentistry

NOTICE OF PRIVACY PRACTICES
(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1966 (“HIPPA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPPA” provides penalties for covered entities that misuse personal health information.

As required by “HIPPA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes; treatment, payment and health care operations.

> **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
>
> **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
>
> **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Family & Cosmetic Dentistry

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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MELUCCI DDS

Family & Cosmetic Dentistry

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name____

Signature____

Date____

OUR CANCELLATION POLICY

We know that your time is valuable and it can hamper your day when one thing is out of sync. The Family and Cosmetic Dentistry Practice of Dr. John C. Melucci would like to do our part in keeping things running smoothly for you and ourselves.

So, in the interest of respecting your time as well as ours we have decided to institute a Late-Cancellation & No Show Policy to begin **May 1, 2010.**

Our Late-Cancellation and No Show Policy is as follows:

- **Our Patients will agree to attend their reserved dental appointments.**
  A "Late-Cancellation" is defined as a change of appointment given *less* than 48 hours notice; the fee for this is $35. A "No Show" is subject to the same fee. If a patient arrives 15 minutes late or more, they may be asked to reschedule and the appointment may be considered "Late-Cancellation".

  Note: Phone calls, text messages and emails are our courtesy reminders to assist our patients in keeping to their appointment times and dates. However, ***even* if a patient does not receive a phone call, text message or email reminder from us, and they do not cancel their appointment according to our policy, they then will be charged a Late-Cancellation/No Show fee.**

- **If a patient is unable to attend their reserved appointment and is unable to provide 48 hours notice due to *an extraordinary circumstance,* he/she is *personally* required *to call and speak to a person in the office to cancel* the appointment. Cancellation messages via voicemail, email, or text are not sufficient.**

  Note: Extraordinary circumstances are conditions that are typically out of the control of the patient and may include but are not limited to: a family tragedy; an illness requiring hospitalization/immediate medical attention; extreme weather conditions. Any extraordinary circumstances will be determined on an individual basis by the practice.

- **Patients may leave a cancellation message on the practice's voicemail if it has been placed *more* than 48 hours prior to the scheduled appointment, which may include weekends, after-hours, or holidays (412-531-6804).**

With this policy and our modified office hours we can better accommodate your busy schedules. Late arrivals, late-cancelled and no show appointments jeopardize the ability of our practice to provide appropriate care for the needs of our valued patients.

We appreciate your understanding and cooperation regarding this matter and we are truly grateful that you have chosen our practice for your dental home.

Dr. John C. Melucci and Team

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CANCELLATION POLICY ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the notice of the cancellation policy and I have been provided an opportunity to review it. I understand that the office of John C. Melucci DDS can and will charge my account in the event that I cancel my appointment with less than 48 hours notice or fail to show up to my scheduled appointment.

Name____

Signature____

Date____

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