HEALTH HISTORY 2021
Linda Lollini DDS, Inc.

Last Name: _____ First _____ DOB _____ Social Security # _____ M / F

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

Phone: (H) _____ (W) _____ (C) _____ Email: _____

Emergency Contact: _____ Relationship: _____ Home/Cell Phone: ( ) _____

Patient's Employer Name: _____ Referred By: _____ Spouse's Name: _____

Physician's Name _____ Physician's Address / Phone # _____

Have you ever had a serious injury to your head or mouth? **Yes / No**

Do you wear dentures or partials? **Yes / No** When were they made? _____

Are you currently experiencing dental pain, discomfort or have dental concerns? **Yes / No** _____

Have you had a serious illness or hospitalizations in the past 5 years? Please list: _____

Are you taking any prescribed medications? Please list: _____

_____

Please mark and (x) to indicate if you have or have not had any of the following diseases or problems.

	Yes No		Yes No		Yes No		Yes No
Heart Disease……	☐ / ☐	Chest pain……	☐ / ☐	Arteriosclerosis……..	☐ / ☐	Congestive Heart Failure	☐ / ☐
Damaged Heart Valves	☐ / ☐	Hemophilia……	☐ / ☐	Heart Murmur……..	☐ / ☐	High Blood Pressure ……..	☐ / ☐
Mitral Valve Prolapse	☐ / ☐	Pacemaker ……..	☐ / ☐	Abnormal Bleeding…..	☐ / ☐	Kidney Problems……	☐ / ☐
AIDS or HIV Infection	☐ / ☐	Autoimmune disease	☐ / ☐	Rheumatoid Arthritis	☐ / ☐	Osteoporosis……	☐ / ☐
Emphysema…….	☐ / ☐	Tuberculosis……	☐ / ☐			Gastric Reflux……	☐ / ☐
Diabetes Type I or II	☐ / ☐	Eating disorder …….	☐ / ☐	Hepatitis List Type ___	☐ / ☐		
Gastrointestinal disease	☐ / ☐	Epilepsy……	☐ / ☐				
Thyroid Problems……..	☐ / ☐	Stroke (When) ……..	☐ / ☐	Cancer (Type / Year) ……	☐ / ☐		
Heart Attack (When)…	☐ / ☐	Neurological Disorders	☐ / ☐	Chemotherapy/Radiation (Type / Year)……	☐ / ☐		

Explain the above (yes) marked items or other disorders not listed:

_____

Allergies (Circle): Penicillin Erythromycin Clindamycin Amoxicillin

NONE Local Anesthetic Metals Latex Other (list) _____

Women: Are you pregnant (# of weeks), attempting to get pregnant, nursing **Yes / No**_____

Premedication:

Have you had a total joint replacement (hip, knee, elbow, finger,…)? **Yes / No**

Have you previously had endocarditis? **Yes / No**

Do you have an artificial heart valve, previous infective endocarditis, damaged heart valves, heart transplant, congenital heart disease (unrepaired, repaired in last 6 months or repaired w/ residual defects)? **Yes / No**

Have you used any medications for osteoporosis or osteopenia, used any antiresorbative agents like Fosamax, Actonel, Boniva, Reclast or have you been treated for Paget's Disease, Multiple myeloma or metastatic cancer with (Aredia, Zometa, XGEVA)? **Yes / No**

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. If I have any changes in my health or medications, I will inform the doctor at my next appointment.

I have been given or shown the offices Dental Materials Fact Sheet and Privacy Practices Policies.

CONSENT:

1. I grant permission for my physician to be contacted for details and advice.
2. I authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
3. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.
4. I understand that all responsibility is mine for payment for dental services provided in this office for both myself and my dependents, even if I have dental insurance.

Signature of Patient / Legal Guardian: _____ **Date:** _____

Signature of Dentist: _____ **Date:** _____

If this form is being completed by someone other than the patient or legal guardian, please list your name and connection to the patient.

Name: _____ **Relationship:** _____

Signature: _____ **Date:** _____

INSURANCE SUMMARY

Patient Name: First _____ Middle Initial _____ Last_____

Date of Last Dental Visit: _____

Have you had Dental Procedures performed at other facilities this year? This will help us to more accurately determine your remaining insurance benefit for the year.

_____

PRIMARY INSURANCE CARRIER

Policy Holder's Name:

First _____ Last_____ Date of Birth: _____

SS # _____ - ____ - _____ Relationship to Patient: _____ Phone #: ( ) _____

Employer: _____ Occupation: _____

Work Address: Address _____ City _____ State _____

Insurance Company: _____ Plan Name: _____

Group or Policy #: _____

Insurance Address: _____ City: _____ State: _____

SECONDARY INSURANCE CARRIER

Policy Holder's Name:

First _____ Last_____ Date of Birth: _____

SS # _____ - ____ - _____ Relationship to Patient: _____ Phone #: ( ) _____

Employer: _____ Occupation: _____

Work Address: Address _____ City _____ State _____

Insurance Company: _____ Plan Name: _____

Group or Policy #: _____

Insurance Address: _____ City: _____ State: _____

CONSENT

1. I authorize this office to communicate with my insurance providers in order to estimate my benefits and submit claims on my behalf.
2. I understand that there is usually an annual deductible fee that I must satisfy before my insurance provider will accept claims
3. I know that insurance providers pay only a percentage of each procedure and that there is an annual maximum of insurance pay out.
4. I accept that my Insurance Provider may deny my claims, and that I will be responsible to pay for the services rendered in this office.
5. I understand that my insurance will have exclusions to coverage. I also understand that there will be situations (ex. Use of benefits at another office) that may not be known by this office despite formulation of a treatment plan and that I will be responsible to pay for the balance of services rendered minus insurance payment despite a treatment plan.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

RELATIONSHIP TO THE PATIENT: _____

FINANCIAL POLICY

LINDA LOLLINI D.D.S. INC.

Accepted types of payment: We accept cash, check, Visa, Mastercard, American Express and Discover. We also offer CareCredit, a health care credit card that may allow you to spread out payments at lower or no interest.

Insurance: Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy. Please note that services are not rendered on the assumption that your insurance company will pay us. Patients are ultimately responsible for payment of all fees generated by treatment. If your insurance has not paid your claim within 90 days after the date of service, the full amount is due and payable by you. We will promptly refund to you any insurance payment excess received after that date. It is your responsibility to inform us of any changes in your insurance coverage. We encourage you to become familiar with your plan to assist in correctly estimating your obligations.

Treatment Plans: When treatment is advised, we will provide you with a treatment plan outlining the procedures, costs and expected insurance contribution. The expected insurance contribution is only an estimate. Treatment plans are not a guarantee of insurance payment.

Insurance Estimates: Your treatment estimate is based on information provided by a contracted service which maintains updated basic insurance details on most plans. We are often not able to find out each plans specific exclusions or in depth coverage details without a lengthy preauthorization process. Your insurance may not pay as listed in the estimate due to factors such as procedure restrictions (ie. nightguard or implant restrictions), age restrictions, pre-existing conditions, downgrading of procedures (ie. tooth colored composite fillings paid as silver fillings), waiting periods and frequency of procedure issues. We are also unable to calculate in benefits used on procedures done at other offices. Insurance plans often set their own fees levels for procedures which may be less than actual charges. We are unable to know these amounts.

Some dental plans require patients to go to specific providers exclusively to receive a higher coverage level. We do not always know such requirements of your plan. We encourage new patients or patients with new insurance to contact your plan to assure if such restrictions apply to you.

Presently, there is a lot of change in the dental insurance industry. As with medical, dental insurance companies are needing to adapt plans to stay competitive for employer contracts in the rapidly changing market. Insurance plans have become rather complex. We have recently seen many insurance companies deny payment for a variety of reasons that we have never seen before or would expect. For all these reasons, estimates may be incorrect despite our best attempts. Please request a Pre-Authorization of coverage from your insurance if you need more specific details, which we can submit. Pre-authorizations are only correct on the day that your insurance forms them. Claims that they receive after may change that amount. Pre-authorizations may take 4-8 weeks to receive a response.

Discounts: We offer either a senior discounts (10%) for patients without insurance or a cash discount (5%).

Past Due Accounts: Accounts become past due when not paid in full 30 days after the statement date unless other arrangements have been made. We understand struggles do arise in families. If such situations do occur, please contact our office promptly.

Returned Checks: There is a fee (currently $50) for any checks returned by the bank.

We appreciate your confidence in us and welcome the opportunity to serve you. If you have any questions about the above information, please do not hesitate to ask.

_____ _____

Patient Name **Signature**

_____ _____ _____

Parent/Guardian Name **Signature (Parent or Guardian)** **Date**

Updated 11/21