DRS. DALESANDRO & WEEGE
FAMILY OWNED SINCE 1978

PATIENT INFORMATION

NAME: ______________________________ BIRTH DATE: ______________ SS#: ______________
LAST FIRST MI

HOME ADDRESS: ____
STREET CITY STATE ZIP

E-MAIL ADDRESS: ____

HOME PHONE: ______________ CELL PHONE: ______________ WORK PHONE: ______________

EMPLOYER: ______________ OCCUPATION: ______________ REFERRED BY: ______________

EMERGENCY CONTACT: ____
NAME PHONE ALTERNATE PHONE

SPOUSE INFORMATION

SINGLE:______ MARRIED:______

NAME: ______________________ OCCUPATION: ______________________

EMPLOYER: ______________________ WORK PHONE: ______________________

PRIMARY SUBSCRIBER INFORMATION

NAME: ______________________________ BIRTH DATE: ______________ SS#: ______________
LAST FIRST MI

MEMBER ID#: ______________________ EMPLOYER: ______________________

PRIMARY DENTAL INSURANCE COMPANY: ______________________ GROUP#: ______________

CLAIMS ADDRESS: ______________________________ TOLL FREE# ______________
STREET CITY STATE ZIP

SECONDARY SUBSCRIBER INFORMATION

NAME: ______________________________ BIRTH DATE: ______________ SS#: ______________

MEMBER ID#: ______________________ EMPLOYER: ______________________

SECONDARY DENTAL INSURANCE COMPANY: ______________________ GROUP: ______________

CLAIMS ADDRESS: ______________________________ TOLL FREE#: ______________
STREET CITY STATE ZIP

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

SELF ______ SPOUSE ______ OTHER ______

NAME: ______________________________ BIRTH DATE: ______________ SS#: ______________
LAST FIRST MI

HOME ADDRESS: ____
STREET CITY STATE ZIP

HOME PHONE: ______________ CELL PHONE: ______________ WORK PHONE: ______________

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HEALTH HISTORY

1. Do you have any pain from any area of your mouth? YES___ NO___ If YES, where?___

2. Are you in good health? YES___ NO___ 3. When was your last physical examination?___

4. Are you now under the care of a physician? YES___ NO___ Physician's Name & Phone: ___

5. Have you been hospitalized or had a serious illness within the past 5 years? YES___ NO___ If YES, explain:___

6. Are you now taking any medication, drugs or pills? YES___ NO___

If YES, please list those medications/drugs & reason:___

7. Y N Conditions	Y N Conditions	Y N Conditions	Y N Conditions	Y N Allergies
☐ ☐ Abnormal Bleeding	☐ ☐ Cosmetic Surgery	☐ ☐ Hemophilia	☐ ☐ Rheumatic Fever	☐ ☐ Aspirin
☐ ☐ Alcohol Abuse	☐ ☐ Diabetes	☐ ☐ Hepatitis A	☐ ☐ Seizures	☐ ☐ Codeine
☐ ☐ Allergies	☐ ☐ Difficulty Breathing	☐ ☐ Hepatitis B	☐ ☐ Shingles	☐ ☐ Dental Anesthetics
☐ ☐ Anemia	☐ ☐ Drug Abuse	☐ ☐ High Blood Pressure	☐ ☐ Sickle Cell Disease	☐ ☐ Erythromycin
☐ ☐ Angina Pectoris	☐ ☐ Emphysema	☐ ☐ HIV+ AIDS	☐ ☐ Sinus Problems	☐ ☐ Jewelry
☐ ☐ Arthritis	☐ ☐ Epilepsy	☐ ☐ Kidney Problems	☐ ☐ Stroke	☐ ☐ Latex
☐ ☐ Artificial Bones	☐ ☐ Fainting Spells	☐ ☐ Liver Disease	☐ ☐ Thyroid Problems	☐ ☐ Metals
☐ ☐ Artificial Heart Valve	☐ ☐ Fever Blisters	☐ ☐ Low Blood Pressure	☐ ☐ Tuberculosis	☐ ☐ Penicillin
☐ ☐ Asthma	☐ ☐ Frequent Headaches	☐ ☐ Mitral Valve Prolapse	☐ ☐ Ulcers	☐ ☐ Tetracycline
☐ ☐ Blood Transfusion	☐ ☐ Glaucoma	☐ ☐ Pace maker	☐ ☐ Venereal Disease	Other
☐ ☐ Cancer-Chemotherapy	☐ ☐ Hay Fever	☐ ☐ Pneumocystitis	☐ ☐ Yellow Jaundice	___
☐ ☐ Colitis	☐ ☐ Heart Attack	☐ ☐ Psychiatric Problems		___
☐ ☐ Congenital Heart Defect	☐ ☐ Heart Surgery	☐ ☐ Radiation Therapy		

8. Do you get up often at night to urinate? YES___ NO___ 9. Are you thirsty much of the time? YES ___ NO ___

10. Has anyone in your family had diabetes? YES___ NO___ 11. Do you smoke? YES___ NO___ How much? ___

12. Do you consider yourself a nervous person? YES___ NO___ 13. Do you take bisphosphonates? YES___ NO___ How much?___

14. Do you have any disease, condition or problem not listed above that you think we should know about? YES___ NO___

If YES, please explian:___

15. FOR WOMEN ONLY; Are you pregnant? YES___ NO___ If YES, what month?___ Are you Nursing? YES___ NO___

CONSENT

I, the undersigned, hereby authorize the Doctor to take radiographs, study models, photographs or any diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor with my verbal consent to perform any and all forms of treatment, medication and therapy after the Doctor explains the condition in connection with (patient) ___, and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand that the use of anesthetic agents embodies risk. I understand that responsibility for payment for dental services provided in this office for myself and/or my dependents is mine, **due and payable at the time services are rendered.** If I do not pay the full balance at the time of service and/or have not made financial arrangements for the balance, I understand that a 1.5% finance charge per month (18% annually) will be added to any balance over 90 days'. **Furthermore, I understand that a cancellation fee of $45 will be charged unless 2 working days' notice is given for appointment changes.**

Signature: ___ Date:___ Relationship to Patient:___

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DENTAL HISTORY

NAME (PLEASE PRINT): ______________________________ DATE: __________
LAST FIRST MI

CHIEF COMPLAINT OR PURPOSE OF THIS APPOINTMENT: __________

DATE OF LAST VISIT: __________ PURPOSE: __________

DATE OF LAST DENTAL CLEANING: __________

DATE OF LAST FULL MOUTH OF X-RAYS: __________

NAME OF PREVIOUS DENTIST: __________ CITY: __________

		YES	NO
ARE YOUR TEETH SENSITIVE TO:	COLD?	______	______
	HEAT?	______	______
	SWEETS?	______	______
	PRESSURE?	______	______
WHEN CHEWING GUM, DO YOU AVOID ONE SIDE?		______	______
IF YES, WHICH SIDE? __________			
DO YOUR GUMS BLEED WHEN BRUSHING?		______	______
DO YOU USE DENTAL FLOSS?		______	______
IF YES, HOW OFTEN?		______	______
DOES THE FLOSS CATCH OR TEAR?		______	______
IF YES, WHERE? __________			
HAVE YOU EVER BEEN INSTRUCTED ABOUT PROPER HOME CARE?		______	______
DOES FOOD CATCH BETWEEN YOUR TEETH?		______	______
IF YES, WHERE? __________			
DO YOU HAVE AN UNPLEASANT ODOR OR TASTE IN YOUR MOUTH?		______	______
DO YOU GRIND OR CLENCH YOUR TEETH?		______	______
DO ANY OF YOUR TEETH FEEL LOOSE?		______	______
IF YES, WHICH? __________			
DO YOU EVER AWAKEN WITH PAIN NEAR YOUR EARS OR JAW MUSCLES?		______	______
DO YOU HEAR CLICKING OR POPPING WHEN YOU CHEW?		______	______
HAVE YOU EVER HAD ORTHODONTIC TREATMENT?		______	______
HAVE YOU EVER BEEN TREATED FOR A BAD BITE?		______	______

Dear Patients,

Please be aware that we charge $45 for failure to give us at least a **2 working days'** notice of change to any existing appointments. In order to avoid this fee, we do appreciate that you will keep this in mind when changing your dental appointments in the future.

Date: ______________ Patient Signed: ____

By signing below I acknowledge that my insurance will be billed as a courtesy, it is my responsibility to know my insurance benefits and limitations.
I understand that payment is due at time of services rendered.

Date: ______________ Patient Signed: ____

Thank you for your understanding in this matter.

Sincerely,
Drs. Dalesandro, Weege & Team

Adam R. Dalesandro, D.M.D. | Benjamin E. Weege, D.D.S
Ph: 327-5993 | Fax: 327-0907 | 762 N Country Club Road | Tucson, AZ 85716 | DrDalesandro.com

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and recieve a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address below to obtain a current copy of said document.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME: ______________________________ DATE: ______________

SIGNATURE: ______________________________

RELATIONSHIP TO PATIENT: ______________________________

Dependent family members also covered by this acknowledgement:

____

____

FOR OFFICE USE ONLY

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

_______ Patient Refused to Sign

_______ Emergency Situation

_______ Communication Barriers

_______ Other

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