Aiello Dental Associates

Caring for friends and family

PATIENT REGISTRATION

First Name :_____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Patient is ❑ Responsible Party ❑ Policy Holder

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ❍ Female ❍ Male Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

Birth date: _____ Social Security #: _____ Driver's License #: _____

E-mail: _____ ❑ I would like to receive email/text correspondences

If student, name of college and address _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ❍Self ❍Spouse ❍Child ❍Other

Employer ID: _____ Social Security #: _____

Insured Birth Date _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: ❍Self ❍Spouse ❍Child ❍Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Patient Medical Questionaire

Patient Name: _____ Birth Date: _____ Date Created: _____

General Single Questions

Are you under a physician's care now other than a primary care physician?	❍ Yes ❍ No	If yes
Have you ever been hospitalized or had a major operation in the past five years?	❍ Yes ❍ No	If yes
Have you ever had a serious head or neck injury that would limit your dental treatment?	❍ Yes ❍ No	If yes
Are you taking any medications, vitamins or Supplements?	❍ Yes ❍ No	If yes
Are you pregnant?	❍ Yes ❍ No	
Are you currently taking oral contraceptives?	❍ Yes ❍ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	❍ Yes ❍ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ❍ Yes ❍ No	Fainting Spells / Dizziness ❍ Yes ❍ No	Kidney Problems ❍ Yes ❍ No	Alzheimer's Disease ❍ Yes ❍ No
Frequent Headaches ❍ Yes ❍ No	Leukemia ❍ Yes ❍ No	Anemia ❍ Yes ❍ No	GERD / Acid Reflux ❍ Yes ❍ No
Liver Disease ❍ Yes ❍ No	Anxiety / Depression ❍ Yes ❍ No	Glaucoma ❍ Yes ❍ No	Low Blood Pressure ❍ Yes ❍ No
Arthritis/Gout ❍ Yes ❍ No	Heart Attack / Failure ❍ Yes ❍ No	MS / Parkinson's ❍ Yes ❍ No	Asthma ❍ Yes ❍ No
Heart Pace Maker ❍ Yes ❍ No	Osteoporosis ❍ Yes ❍ No	Blood Transfusion ❍ Yes ❍ No	Heart Trouble / Disease ❍ Yes ❍ No
Pain In Jaw Joints ❍ Yes ❍ No	Bruise Easily ❍ Yes ❍ No	Heart Valve Replacement ❍ Yes ❍ No	Radiation Treatments ❍ Yes ❍ No
Cancer ❍ Yes ❍ No	Hemophilia ❍ Yes ❍ No	Rheumatic Fever ❍ Yes ❍ No	Celiac Disease ❍ Yes ❍ No
Hepatitis A, B, C ❍ Yes ❍ No	Sexual Transmitted Disease ❍ Yes ❍ No	Chemotherapy ❍ Yes ❍ No	High Blood Pressure ❍ Yes ❍ No
Shingles ❍ Yes ❍ No	Cold Sores / Fever Blisters ❍ Yes ❍ No	High Cholesterol ❍ Yes ❍ No	Sickle Cell Disease ❍ Yes ❍ No
Convulsions ❍ Yes ❍ No	Hives / Rash ❍ Yes ❍ No	Stroke ❍ Yes ❍ No	Diabetes ❍ Yes ❍ No
Hypoglycemia ❍ Yes ❍ No	Thyroid Disease ❍ Yes ❍ No	Emphysema / COPD ❍ Yes ❍ No	IBS / Crohn's ❍ Yes ❍ No
Tuberculosis ❍ Yes ❍ No	Epilepsy or Seizures ❍ Yes ❍ No	Joint Replacement ❍ Yes ❍ No	Other Diseases Not Listed ❍ Yes ❍ No
Excessive Bleeding ❍ Yes ❍ No			

Allergies

Are you allergic to any of the following?

Aspirin	❍ Yes ❍ No
Metal	❍ Yes ❍ No
Penicillin	❍ Yes ❍ No
Latex	❍ Yes ❍ No
Codeine	❍ Yes ❍ No
Sulfa Drugs	❍ Yes ❍ No
Acrylic	❍ Yes ❍ No
Local Anesthetics	❍ Yes ❍ No
Nuts	❍ Yes ❍ No
Other	❍ Yes ❍ No
Seasonal	❍ Yes ❍ No

Signature

Signature of Patient, Parent of Guardian:

_____ Date:_____

X

Aiello Dental Associates

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Aiello Dental Asssociates

Caring for friends and family

11521 Parkway Drive
North Huntingdon, PA 15642
724-863-9100

Email: faiellodentist@gmail.com
www.aiellodental.com

Frank D. Aiello, D.D.S.

American Dental Association

Pennsylvania Dental Association

Fellow of the Academy General Dentistry

International Academy of Mini Dental Implants

Provider for Clear Correct Clear Aligner Therapy

Financial Policy

To Our Patients:

Payments in full are required at each visit unless prior arrangements have been made with the Business Office.

- Besides payment by cash or check, we also accept Visa, MasterCard, American Express and Discover

If you have insurance, please be aware that ultimately the patient is responsible for any amounts not covered by insurance. We offer insurance billing as a courtesy to our patients.

1. Complete insurance information is need on the day of your visit or payment in full will be required for services and a receipt will be issued for reimbursement from your insurance company.

2. Information required for filing insurance claims is as follows:

Policyholder's:
- Name & relations to patient
- Social security number
- Date of birth
- Employer
- Insurance company name, address & phone number
- Group number
- Address if different than patient

3. Payment is required at each office visit for co-payments & deductibles. If you are unfamiliar with your insurance plan, the Business Office will estimate co-payments.

4. Changes in insurance information are the responsibility of the patient. Any claim amounts rejected due to insufficient or incorrect insurance information will be billed to the patient and are due upon receipt.

I have read and understand the financial policy of Aiello & Cobb Dental Associates and agree to the provisions provided herein.

Signature _____ Date_____