WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

I. ABOUT YOU

Name: _____ Sex ☐ Male ☐ Female
Last First MI Preferred Name

Street Address_____ Apt# City State Zip

Mailing Address_____ Apt# City State Zip

Birthdate: _____/_____/_____ Age: _____ SS#:_____ DL #: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: _____ Work #: _____ Ext _____ Cell #: _____

Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____ Phone: _____

In case of an emergency, who should be notified?

Name: _____ Phone: _____

How did you hear about us?_____

If someone referred you, please indicate name: _____

May we use your name in thanking this person? YES ☐ NO ☐

Preferred Pharmacy (**Pharmacy name AND location(city/street)**): _____

I will be paying today by ☐ Cash ☐ Check ☐ Credit Card

II. SPOUSE INFORMATION

Name: _____ DOB: _____

Employer: _____ Occupation: _____

WK#: _____ Ext _____ Cell _____ SS#: _____

III. DENTAL INSURANCE

Do you have dental insurance? ☐ Yes ☐ No

If yes, please present front office with your card NOW, before going back to treatment area.

IV. DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor Do your gums bleed? ☐Yes ☐ No

How many times a week do you floss? _____ A day do you brush? _____

Do you wish your teeth were: WHITER? ☐ Yes ☐ No STRAIGHTER? ☐ Yes ☐ No

Why did you leave your last dentist?_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I authorize the dental staff to take photographs of my teeth and oral tissues as part of my dental records for professional and educational use.**

_____

PATIENT SIGNATURE **DATE**

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐Yes	☐ No	If yes, explain_____
Have you ever been hospitalized or had a major operation?	☐Yes	☐ No	If yes, explain_____
Have you ever had a serious head or neck injury?	☐Yes	☐ No	If yes, explain_____
Are you taking any medications, pills, or drugs?	☐Yes	☐ No	If yes, list_____
Do you take, or have you taken, Phen-Fen or Redux?	☐Yes	☐ No	If yes, when_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐Yes	☐ No	If yes, explain_____
Are you on a special diet?	☐Yes	☐ No	If yes, explain_____
Do you use tobacco?	☐Yes	☐ No	
Do you use controlled substances?	☐Yes	☐ No	

WOMEN: Are you.....
☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?
☐Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
Other: _____

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

AIDS/HIV Positive	☐Yes	☐ No	Fainting Spells/Dizziness	☐Yes	☐ No	Lung Disease	☐Yes	☐ No
Alzheimer's Disease	☐Yes	☐ No	Frequent Cough	☐Yes	☐ No	Mitral Valve Prolapse	☐Yes	☐ No
Anaphylaxis	☐Yes	☐ No	Frequent Diarrhea	☐Yes	☐ No	Osteoporosis	☐Yes	☐ No
Anemia	☐Yes	☐ No	Frequent Headaches	☐Yes	☐ No	Pain in Jaw Joints	☐Yes	☐ No
Arthritis/Gout	☐Yes	☐ No	Glaucoma	☐Yes	☐ No	Parathyroid Disease	☐Yes	☐ No
Artificial Heart Valve	☐Yes	☐ No	Heart Attack/Failure	☐Yes	☐ No	Psychiatric Care	☐Yes	☐ No
Artificial Joint	☐Yes	☐ No	Heart Murmur	☐Yes	☐ No	Radiation Treatments	☐Yes	☐ No
Asthma	☐Yes	☐ No	Heart Pacemaker	☐Yes	☐ No	Recent Weight Loss	☐Yes	☐ No
Blood Disease	☐Yes	☐ No	Heart Trouble/Disease	☐Yes	☐ No	Renal Dialysis	☐Yes	☐ No
Blood Transfusion	☐Yes	☐ No	Hemophilia	☐Yes	☐ No	Shingles	☐Yes	☐ No
Breathing Problems	☐Yes	☐ No	Hepatitis A	☐Yes	☐ No	Sickle Cell Disease	☐Yes	☐ No
Bruise Easily	☐Yes	☐ No	Hepatitis B	☐Yes	☐ No	Sinus Trouble	☐Yes	☐ No
Cancer	☐Yes	☐ No	Hepatitis C	☐Yes	☐ No	Spina Bifida	☐Yes	☐ No
Chemotherapy	☐Yes	☐ No	Herpes	☐Yes	☐ No	Stomach/Intestinal	☐Yes	☐ No
Chest Pains	☐Yes	☐ No	High Blood Pressure	☐Yes	☐ No	Stroke	☐Yes	☐ No
Cold Sores/Fever Blisters	☐Yes	☐ No	High Cholesterol	☐Yes	☐ No	Thyroid Disease	☐Yes	☐ No
Congenital Heart	☐Yes	☐ No	Hives or Rash	☐Yes	☐ No	Tonsilitis	☐Yes	☐ No
Diabetes	☐Yes	☐ No	Hypoglycemia	☐Yes	☐ No	Tuberculosis	☐Yes	☐ No
Drug Addiction	☐Yes	☐ No	Kidney Problems	☐Yes	☐ No	Tumors or Growths	☐Yes	☐ No
Emphysema	☐Yes	☐ No	Leukemia	☐Yes	☐ No	Ulcers	☐Yes	☐ No
Epilepsy or Seizures	☐Yes	☐ No	Liver Disease	☐Yes	☐ No	Venereal Disease	☐Yes	☐ No
Excessive Bleeding	☐Yes	☐ No	Low Blood Pressure	☐Yes	☐ No			

Have you ever had any illness not listed above? ☐Yes ☐ No If yes, explain _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information cn be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient **Printed** Name: Date of Birth:

SIGNATURE of patient/parent: Date:

JAMES ARISCO, DDS

Informed Consent for Services

Patient Name: _____

Initials _____ **DRUGS, MEDICATIONS, AND LOCAL ANESTHESIA**

I understand that antibiotics, analgesics, and other medications can cause allergic reactions: redness, swelling, itching, pain, and/or anaphylactic shock. I understand that some medications may cause drowsiness and lack of coordination which can increase with the use of alcohol or other drugs. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain with the potential resistance to effective treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

Initials _____ **CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to Dr. Arisco to make any/all changes and additions as necessary.

Initials _____ **PERIODONTAL TREATMENT**

I understand that periodontal disease is a serious, progressive infection, causing gum inflammation and deterioration, bone loss, and can lead to loss of teeth. I understand that after treatment there can be tenderness, swelling, pain, sensitivity to temperature, and/or bleeding. Alternative treatment is available, including gum surgery, replacement teeth and extractions. I understand that success depends in part on my efforts to brush, floss, and use prescribed mouthwash daily, follow maintenance schedule, and other recommendations.

Initials _____ **FILLINGS**

I understand that a more extensive filling than originally diagnosed may be required due to additional decay not seen on an x-ray. I understand that sensitivity to cold or pressure is common after newly placed fillings. I understand that the most common complications are sensitivity to temperature, fracture of the tooth, nerve damage, damage to the teeth, bite changes, and TMJ complications. I understand that all these complications are more likely the longer I wait to seek treatment.

Initials _____ **CROWNS AND BRIDGES**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crown(s), which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days of the preparation date. Excessive delay may allow tooth movement or failure in the temporary, which may necessitate remakes. I understand there will be additional charges for remakes due to me delaying permanent cementation.

I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I hereby authorize Dr. James Arisco and dental team to proceed with the dental procedures/treatments as have been explained to me. I understand this is only an estimate and subject to modification depending on unforeseen or diagnosable circumstances that may arise during the course of treatment. I understand that regardless of any insurance coverage I may have, I am responsible for full payment of treatment fees.

Signature of Patient/Responsible Party _____ Date_____

Signature of dental team member _____ Date_____

COVID-19 Patient Consent

I, _____ (Patient or Parent/Guardian), knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.
I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.
Dental procedures create water spray which is how the disease spreads. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. _____ **(Initial)**
I confirm that I am not presenting any of the following COVID-19 symptoms: _____ **(Initial)**

- Fever and/or chills
- Shortness of breath
- Dry cough
- Runny nose
- Muscle pain
- Sore throat
- New Loss of taste or smell

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. _____ **(Initial)**

I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. _____ **(Initial)**
I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____ **(Initial)**

I understand that I will contact the office (and my Primary Care Physician) if I develop any COVID-19 symptoms within the next 14 days.

I understand that Dr. Arisco and his dental team staff have answered all my questions regarding COVID-19, as well as the infection control standards the office has implemented.

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____

JAMES A. ARISCO, D.D.S.

3151 Saba Lane
Port Neches, TX 77651
P (409) 722-8404
F (409) 722-8503

Patient Medication List

Patient Name: _____ Date of Birth: _____

Medication Name	**Prescribing Physician**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	

This is a current list of all medications, including both prescription and over the counter medications, I am currently taking.

Patient Printed Name: Patient Signature Date

JAMES A. ARISCO, D.D.S

3151 Saba Lane
Port Neches, TX 77651
(409)722-8404
(409)722-8503

OUR FINANCIAL POLICY

We are committed to providing our patients with the best quality dental care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Following the initial evaluation, Dr. Arisco will develop a ***Proposed Treatment Plan***. This plan will include a detailed report of any necessary treatment listed in order of priority as well as the fee to be charged for each service. The treatment plan is subject to modification depending on any unforeseen or diagnosable circumstances that may arise during the course of treatment.

PAYMENT PROCECURE

- All deductibles, co-pays, and estimated patient portion of fees are due at the time of service. Any past due balances must be paid prior to scheduling any future appointments.
- Payment will be collected from the patient/responsible party prior to seating the patient to begin the scheduled procedure.
- Payment methods we accept include **cash, money order, VISA, MasterCard, Discover,** and **CareCredit.**
- In the event the patient does not have the required payment due for the scheduled procedure, the appointment must be rescheduled.

DENTAL INSURANCE

As a courtesy to our patients who have dental insurance, we will file your insurance claim for you. However, if we do not receive payment from your insurance company within 45 days of filing, you will be required to make payment in full. Your insurance policy is a contract between you and your insurance company. You are solely responsible for your account**.**

- **Insurance information and changes must be obtained at least 2 days prior to your appointment to allow us adequate time to verify your dental insurance benefits.**
- **It is your responsibility to report any changes to your employer and/or insurance company to our office as soon as possible to avoid delay in payment of claims.**

FINANCE CHARGES

Finance charges will be applied to all accounts over 45 days past due.

COLLECTION PROCEDURES

In the event that a collection agency and/or an attorney must be retained in order to settle an account, you will be responsible for any and all collection fees.

DIVORCE & DEPENDANT CHILDREN

Divorce is a civil action between spouses. The amount due for a child's dental treatment is required to be paid at the time of service by the parent accompanying the child to their appointment. This office will not bill divorced parents separately for their portion. This is to be settled between the child's parents. If there is a remaining balance on the account after the insurance pays, an invoice will be mailed to and is payable by the person listed as the responsible party.

MISSED APPOINTMENTS & CANCELLATION POLICY

In order to provide the best dental care in a timely manner, we ask that you be on time for your scheduled appointment and if unable to keep your appointment, we ask that you kindly give our office at least a **48 business hour notice**. **If you need to cancel your appointment and it is after hours, please leave a text message or voicemail on our answering machine. A $50.00 cancellation/no show fee will be charged for all missed appointments or those not cancelled in advance.** This fee must be paid prior to scheduling any future appointments. We do of course understand that emergency situations/illnesses can occur; therefore extenuating circumstances will be taken into consideration.

Re-establishment Following Absence of Care

If for whatever reason a patient is absent (not received dental treatment) from this practice for 3 years or more, the individual must be re-established as a patient and will be subject to all new patient office procedures. This is standard procedure for all medical offices as directed by the federal government.

Thank you in advance for your understanding of Our Financial Policy. If you have questions or concerns regarding this policy, we will gladly discuss them with you.

JAMES A. ARISCO, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

{**Please Print Name**}

_____

{**Signature**}

_____

{**Date**}

JAMES A. ARISCO, D.D.S.

FINANCIAL POLICY ACKNOWLEDGEMENT

I have received a copy of the James A. Arisco, D.D.S. Office Financial Policy.

_____

{**Please Print Name**}

_____

{**Signature**}

_____

{**Date**}

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

JAMES A. ARISCO, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

CHOOSE ONE & THEN PRINT, SIGN & DATE BELOW

I, _____, have read this office's Notice of Privacy Practices and **DO NOT** authorize release of my information regarding my dental care, appointments, treatment, reports/findings, etc. to the person(s) listed below. This authorization will remain in effect until further notice.

OR

I, _____, have read this office's Notice of Privacy Practices and **DO** authorize release of my information regarding my dental care, appointments, treatment, reports/findings, etc. to the person(s) listed below. This authorization will remain in effect until further notice.

_____	_____	_____
Name	Relation to Patient	Phone Number
_____	_____	_____
Name	Relation to Patient	Phone Number
_____	_____	_____
PATIENT'S PRINTED NAME	**PATIENT'S SIGNATURE**	**DATE**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____