LARRY E. MANALO, D.M.D. 2019

Circle desired home office: **88 DENTAL / PINEBRIDGE DENTAL**

Name _____ Social Security # _____ Date of Birth _____

Address _____ City, State, Zip _____

E-mail _____ Referred by: _____

(You will receive an electronic appointment card via email when appointments are made to the email provided.) (We require at least 2 (two) or more contact phone numbers on account.)

Cell #: _____ Spouse/Parent Cell#: _____ Landline #: _____ Work/Other #: _____

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

List family members that are seen at this office: _____

Dental Carrier Name _____ Phone # _____

(Please attach your dental card so that we may make a copy. Thank you!)

Subscriber Name _____ ID# _____ DOB _____ Employer / Group # _____

Other (2nd) Dental Insurance _____ Phone # _____

(For Minors please include medical insurance information – there is additional coverage for minors under 19 years of age through the Affordable Care Act. Please attach your medical cards so that we may make a copy. Thank you!)

Subscriber Name _____ ID# _____ DOB _____ Employer / Group # _____

Medical Information

What is your general state of health?
Excellent / Good / Fair / Poor

Are you under the care of a physician?
Explain: _____

Recent hospitalization? (w/I 2 years)
Explain: _____

ADHD/ Learning Disability	YES / NO
AIDS / HIV Infection	YES / NO
Alcohol / Drug Abuse	YES / NO
Anemia / Blood Disorder	YES / NO
Anesthetic Reaction	YES / NO
Antibiotic Reaction	YES / NO
Anger Management Issues	YES / NO
Ankles Swell	YES / NO
Anorexia / Bulimia	YES / NO
Arthritis	YES / NO
Asthma / Hay Fever	YES / NO
Autism / Asperger's	YES / NO
Blood Clotting Problems	YES / NO
Blood Transfusion	YES / NO
Bronchitis	YES / NO
Cancer / Tumor	YES / NO
Cardiac Pacemaker	YES / NO
Cerebral Palsy	YES / NO
Chemotherapy / Radiation	YES / NO
Damaged Heart Valve	YES / NO
Developmental Delays	YES / NO
Diabetes	YES / NO
Dizziness / Fainting Spells	YES / NO
Downs Syndrome	YES / NO
Emphysema	YES / NO
Environmental Allergies	YES / NO
Epilepsy / Seizure	YES / NO
Excessive Bleeding	YES / NO
Gall Bladder Trouble	YES / NO
Glaucoma	YES / NO
Headaches-Frequent/Severe	YES / NO
Heart Disease / Angina	YES / NO
Heart Attack / Stroke	YES / NO
Heart Lesions / Congenital	YES / NO
Heart Murmur	YES / NO
Heart Prosthetic / Bypass	YES / NO
Hepatitis	YES / NO
Herpes	YES / NO
High Blood Pressure	YES / NO
Hives / Skin Rash	YES / NO
Jaundice	YES / NO
Joint / Hip Replacement	YES / NO
Kidney Disease	YES / NO
Leukemia	YES / NO
Liver Disease	YES / NO
Low Blood Pressure	YES / NO
Lung Disease	YES / NO
Mitral Valve Prolapse	YES / NO
Multiple Sclerosis	YES / NO
Pregnant / Chance of?	YES / NO
Psychiatric / Mental Care	YES / NO
Sexually Trans. Disease	YES / NO
Shortness of Breath	YES / NO
Sinus Trouble	YES / NO
Special Needs Patient	YES / NO
Stroke	YES / NO
Stomach Ulcers	YES / NO
Thyroid Disease	YES / NO
Tobacco Use (Any)	YES / NO
Tuberculosis	YES / NO
Ulcer / Colitis	YES / NO
Urinate Frequently	YES / NO

_____
_____
_____

HIPAA – PRIVACY PRACTICES:

"I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: 1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); 2. Obtaining payment from third party payers (e.g. my insurance company); 3. The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected."

CANCELLATION / NO SHOW / LATE POLICY:

*** 24-hour notice is required for all cancellations. ($50 fee if not).**
*** It is my responsibility to keep the appointments that I schedule and arrive *on time*. Cancellations, no shows, or being late without proper notice may result in termination from our office.**
*** Your appointment may be rescheduled without notice if we are unable to contact your or confirm your dental appointment.**

COMPLETION OF TREATMENT:

*** It is my responsibility to return to Larry E. Manalo, D.M.D. to complete dental treatment within 4 months of the start date of service or I may incur an extra charge for any procedure that requires extra time, services, or lab work in order to complete a previously started service.**

INSURANCE/PAYMENTS:

***Payment is due at the time of service.**
***Insurance estimates are not a guarantee of payment & I am responsible for any service not paid by insurance.**
***We are an amalgam free office. If white fillings are not covered by insurance you will be billed the difference.**
***I will forward to Larry E. Manalo, DMD directly any insurance payments that are mailed directly to me within 30 days.**

PREVIOUS DENTIST NAME: _____
Date of last dental visit: _____
Reason for today's visit: _____

Dental Information

Bleeding Gums	YES / NO
Bad Breath / Halitosis	YES / NO
Blisters / Ulcers / Sores	YES / NO
Dry Mouth	YES / NO
Difficulty Eating	YES / NO
Injury to Teeth/Jaws	YES / NO
Orthodontics (Braces)	YES / NO
Partials / Dentures	YES / NO
Periodontal (Gum) Disease	YES / NO
Root Canal Treatments	YES / NO
Sensitive Hot/Cold/Sweets	YES / NO
Surgery of Mouth / Jaws	YES / NO
TMJ (Jaw Joint) Problem	YES / NO
Toothaches / Sensitivity	YES / NO
Tooth Grinding / Clenching	YES / NO
Wisdom Teeth Removed	YES / NO
Extreme Dental Nervousness	YES / NO

_____
_____

Taking Medications For:

Allergy	YES / NO
Aspirin	YES / NO
Arthritis	YES / NO
Asthma/COPD	YES / NO
Beta Blockers/Combo	YES / NO
Blood Thinners	YES / NO
Blood Pressure	YES / NO
Cancer	YES / NO
Cholesterol	YES / NO
Depression	YES / NO
Diabetes	YES / NO
Opioids	YES / NO
Pain Relievers	YES / NO
Psoriasis	YES / NO
Steroids	YES / NO
Stimulants	YES / NO

Allergic Reactions To:

Aspirin	YES / NO
Amoxicillin	YES / NO
Ampicillin	YES / NO
Barbiturates /Sleeping Pills	YES / NO
Codeine / Other Narcotics	YES / NO
Epinephrine	YES / NO
Erythromycin	YES / NO
Iodine	YES / NO
Latex Rubber	YES / NO
Local Anesthetics	YES / NO
Metals	YES / NO
Penicillin	YES / NO
Sulfa	YES / NO

Other: _____
_____
_____

Current Medications List: _____

_____

PATIENT DISCLOSURES – My signature below affirms that I understand and accept the HIPPA, cancellation, completion of treatment disclosures, and insurance/ payments, as listed on this form. Use the reverse side of this form to notate any additional information as necessary.

Signature _____ Date _____ Reviewed by Dr. _____ Date _____

(Patient or responsible party if patient is a minor)

(Rev. 1/2019)