Donato A. Valente DDS, PC

3505 Hill Boulevard | Suite D • Yorktown Heights, NY 10598 (914)962-2828

Patient Screening Form

Patient Name: ____________________ ____________________ ____ ____________________

Last First MI Preferred Name

Do you have COVID 19 ◯ Yes ◯ No

Have you had COVID 19 and if so when did you test positive ____________________

Do you have fever or have you felt hot or feverish recently (14-21 days)? * ◯ Yes ◯ No

Are you having shortness of breath or other difficulties breathing? * ◯ Yes ◯ No

Do you have a cough? * ◯ Yes ◯ No

Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? * ◯ Yes ◯ No

Have you experienced recent loss of taste or smell? * ◯ Yes ◯ No

Are you in contact with any people that have been confirmed COVID-19 positive?
*Patient's who are well but have a sick family member at home with COVID-19 should consider postponing elective treatment. *
◯ Yes ◯ No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? * ◯ Yes ◯ No

Have you traveled in the past 14 days to any regions affected by COVID-19? * ◯ Yes ◯ No

☐ *By checking this box, I acknowledge that I have reviewed ALL questions on this forms and responded accordingly. I acknowledge that I must notify the practice of any future changes. This will serve as my electronic signature.

In Office Use ONLY:

Response Date: ____________

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Welcome to our Practice

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ Last ____________ First ____ MI ____________ Preferred Name

Title: ________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

Email Address: ________________________ **Best time to call:** ____________

Phone: ________ Home ________ Mobile ________ Work ____ Ext ________ Fax ________ Other

Address: ____________________ Address 1 ____________________ Address 2

____________________ City ______ State _____-____ Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ________________________ **Phone:** ____________

Employer Address: ____________________ Address 1 ____________________ Address 2

____________________ City ______ State _____-____ Zip Code

How did you hear about our practice?

____

In an emergency who should be notified? Please enter Name and Phone number below:

____

____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Title: ________ Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: ________ SS#: ___-__-____ DL#: ____________

Email Address: ____________ Best time to call: ____________

Phone: ________ ________ ________ ____ ________ ________
Home Mobile Work Ext Fax Other

Address: ____________ ____________
Address 1 Address 2

____________ ____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: ____________ ____________ ____
Last First MI

Insured's Birth Date: ________ ID #: ________ Group #: ________

Insured's Address: ____________ ____________
Address 1 Address 2

____________ ____ _____-____
City State Zip Code

Insured's Employer Name: ____________

Employer Address: ____________ ____________
Address 1 Address 2

____________ ____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____________

Insurance Address: ____________ ____________
Address 1 Address 2

____________ ____ _____-____
City State Zip Code

Insurance Company Phone Number:

____

____

Insurance Authorization:

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours. There will be a fee of $100.00 assessed if we do not receive a call to cancel an appointment.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Cancellation Policy.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: ____________

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Medical History

Patient Name: ______________ ______________ ____ ______________

Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ *Premedicate	☐ *Premedicate amoxi	☐ *Premedicate clindam	☐ *Premedicate erythro
☐ Allergies	☐ Allergy-Amoxicillin	☐ Allergy-Amoxiclav	☐ Allergy-Aspirin
☐ Allergy-Bactrim	☐ Allergy-Codeine	☐ Allergy-Erythromycin	☐ Allergy-Iodine
☐ Allergy-Latex	☐ Allergy-Motrin	☐ Allergy-Naprosyn	☐ Allergy-Peanut
☐ Allergy-Penicillin	☐ Allergy-Percocet	☐ Allergy-Seasonal	☐ Allergy-Sulfa
☐ AllergyTetracycline	☐ Anemia	☐ Anxiety	☐ Aortic Anuerism
☐ Arthritis	☐ Artificial Joints	☐ Asthma	☐ Blood Disease
☐ Cancer	☐ Chemo/Radiation	☐ Diabetes	☐ Dizziness
☐ Emphysema	☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting
☐ Glaucoma	☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur
☐ Heart Stents	☐ Hepatitis	☐ High Blood Pressure	☐ High cholesterol
☐ HIV	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Migrains	☐ Multiple Sclerosis	☐ MVP	☐ Nervous Disorders
☐ NO EPINEPHRINE	☐ Osteoporosis	☐ Other	☐ Pacemaker
☐ Pregnant	☐ Psychiatric care	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ STD	☐ Stent
☐ Stomach Problems	☐ Stroke	☐ Thyroid disease	☐ Tonsilitis
☐ Tuberculosis	☐ Tumors & Growths		

☐ Hospitalized (illness or injury) in the past 5 yrs.	☐ Presently being treated for any other illnesses	☐ Subject to frequent headaches
☐ Tobacco/Vaping Use	☐ Alcohol Use	☐ Bisphosphonate Use
☐ FEMALE: Taking birth control	☐ FEMALE: Nursing	

If any conditions or alerts selected above need further clarification, please describe below:

____

____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

____

____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and phone number:

____

____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

Preferred Pharmacy Location and Phone Number:

Please list any medications you are currently taking, one medication per line:

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

- [ ] Had complications from past dental treatment
- [ ] Had trouble getting numb
- [ ] Had any reactions to local anesthetic
- [ ] Had/have braces, orthodontic treatment
- [ ] You experience dry mouth
- [ ] Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- [ ] Food gets trapped between any teeth
- [ ] Have you ever whitened or bleached your teeth
- [ ] Have you experienced popping and/or clicking of your jaw joint
- [ ] You have difficulty chewing
- [ ] You clench or grind your teeth
- [ ] You wear or have worn a bite appliance
- [ ] You wear partials or dentures
- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury)
- [ ] Experienced a burning sensation in your mouth
- [ ] You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

____

____

- [ ] *By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

____

Response Date: __________